Comprehensive State Plan

2012-2018

Virginia Department of Behavioral Health and Developmental Services

December 2011

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Comprehensive State Plan 2012-2018

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Comprehensive State Plan 2012-2018
Executive Summary

Section 37.2-315 of the C*ode of Virginia* requires the Department of Behavioral Health and Developmental Services (Department) to develop and update biennially a six-year Comprehensive State Plan. The plan must identify the services and supports needs of persons with mental health or substance use disorders or intellectual disability across Virginia; define resource requirements for behavioral health and developmental services; and propose strategies to address these needs. This section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

Services System Overview: Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for the behavioral health and developmental services system. The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment and prevention services and supports for individuals and their families whose lives are affected by mental health or substance use disorders or intellectual disability.

The Department seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals and is committed to implementing the vision "of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of individual participation in all aspects of community life, including work, school, family and other meaningful relationships" *(State Board Policy 1036 (SYS) 05-3).*

Virginia's public services system includes nine state hospitals, five training centers (one of which provides administration services to a medical center, and a sexually violent predator rehabilitation center that are operated by the Department and 39 community services boards and one behavioral health authority (referred to as CSBs) established by local governments.

- CSBs are responsible for delivering community behavioral health and developmental services, either directly or through contracts with private providers. They are single points of entry into the publicly funded behavioral health and developmental services system, with responsibility and authority for assessing individual needs, providing an array of services and supports, and managing state-controlled funds for community-based services.

  In FY 2011, CSBs provided mental health services to 107,892 individuals, developmental services to 20,387 individuals, substance abuse services to 36,769 individuals, and emergency, motivational treatment, consumer-monitoring, and early intervention and assessment and evaluation services and consumer-run programs that are not included above in a specific program area to 86,881 individuals, for an unduplicated total of 196,951 individuals who received some type of behavioral health or developmental service. Although the total number of individuals served by CSBs continues to increase, the CSBs continue to confront waiting lists for services. Between January and April 2011, 14,004 individuals were waiting to receive at least one CSB service.

- State facilities provide highly structured intensive inpatient treatment and habilitation services. Current operating capacities are 1,514 beds in state hospitals, 1,346 beds in training centers, 87 beds at Hiram Davis Medical Center, and 300 beds at the Virginia Center for Behavioral Rehabilitation. In FY 2011, state facilities served 6,338 individuals, a 5.8 percent decrease from FY 2010.

In FY 2011, total behavioral health and developmental services system funding was $2.2298 billion, of which:

  - Community services funding was $1.687.3 million or 73 percent of total system funding,
  - Facility services funding was $571.1 million or 25 percent of total system funding, and

- Department central office funding was $39.5 million or 2 percent of total system funding.

Funding for Virginia's public behavioral health and developmental services system comes from a variety of sources, including state general funds, local matching dollars, federal grants, and fees, including Medicaid.

Estimated Prevalence: By applying prevalence rates from national epidemiological studies and the National Household Surveys on Drug Use and Health to the 2010 U.S. Census counts, the Department estimates that:

- Approximately 239,747 adults in Virginia have had a serious mental illness during the past year.
- Between 84,978 and 103,861 children and adolescents have a serious emotional disturbance, with between 47,210 and 66,094 exhibiting extreme impairment.
- Approximately 144,018 individuals are conservatively estimated to have a developmental disability, of which 73,890 (ages 6 and older) have intellectual disability and 1 in 91 children have an autism spectrum disorder.
- Approximately 18,427 infants, toddlers, and young children (birth through age 5) have developmental delays requiring early intervention services.
- Approximately 187,669 adults and adolescents (ages 12 -18) abuse or are dependent on any illicit drug, with 130,081 meeting the criterion for dependence, and 517,613 adults and adolescents abuse or are dependent on alcohol, with 242,547 meeting the criterion for dependence.

However, only a portion of persons with diagnosable disorders will need services at any given time, and an even smaller portion will require or seek services from the public sector.

CSB Waiting Lists: During the first quarter of calendar year 2011, CSBs completed a point-in-time survey of each person identified by the CSB as being in need of specific services. To be included on the waiting list for CSB services, a person had to have sought the service and been assessed by the CSB as needing that service. CSB staff also reviewed their active cases to identify individuals who were not receiving all of the amounts or types of services that they needed. CSBs identified a total of 14,004 individuals who were waiting for services. Of these:

- 5,716 (4,017 adults and 1,699 children and adolescents) were reported to need mental health services;
- 6,415 (4,040 adults and 2,375 children and adolescents) were reported to need developmental services; and
- 1,873 (1,772 adults and 101 adolescents) were reported to need substance abuse treatment services.

This count includes 108 individuals who were on mental health and substance abuse treatment services waiting lists, 76 individuals who were on mental health and developmental services waiting lists, and one person who was on waiting lists for developmental and substance abuse treatment services.

This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year.

Services System Strategic Initiatives: Behavioral health and developmental services system strategic initiatives included in the Comprehensive State Plan 2012-2018 incorporate the following *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* focus areas:

Behavioral Health Services

1. Emergency response system for individuals in crisis;
2. Peer and recovery support services;
3. Substance abuse treatment services;
4. State hospital effectiveness and efficiency; and
5. Child and adolescent behavioral health services.

Developmental Services

1. Community developmental services and supports capacity; and
2. Autism spectrum disorder and developmental disabilities services and supports.

Systemwide Supports and Services

1. Housing;
2. Employment opportunities; and
3. Case management system capability.

Other strategic initiatives included in the Comprehensive State Plan 2012-2018 follow.

1. Services system quality improvement and accountability;
2. State facility electronic health record system and health information exchange;
3. Cultural and linguistic competency;
4. Civil commitment of sexually violent predators; and
5. State facility capital infrastructure and energy efficiency.

Summary of Resource Requirements: The following capacity development priorities respond to critical issues facing Virginia's behavioral health and developmental services system. Implementation of these capacity development priorities is contingent on resource availability.

Behavioral Health Services Investment Priorities

- Expand statewide capacity and fill identified gaps in emergency and crisis response services and expand services that prevent or reduce the need for crisis response services. Based on a statewide assessment, these services include local purchase of inpatient psychiatric services, Programs of Assertive Community Treatment (PACT), police reception and drop-off program, emergency critical time intervention services, and Crisis Intervention Teams (CITs).
- Enhance state hospital effectiveness and efficiencies by decreasing forensic pressures on state hospitals with expanded funds for Discharge Assistance Project (DAP) placements, outpatient restoration services, and outpatient forensic evaluations; enhancing Southern Virginia Mental Health Institute forensic capacity; and addressing capacity issues at Northern Virginia Mental Health Institute and Commonwealth Center for Children and Adolescents.
- Expand statewide capacity and fill identified gaps in substance abuse treatment services and implement a substance abuse services workforce development initiative. Based on a statewide assessment, these services include case management, community diversion services for young non-violent offenders, intensive outpatient services, detoxification services, adolescent services, medication assisted treatment, residential services for pregnant women and women with dependent children in Southwest Virginia, intensive coordinated care for pregnant and post-partum women (Project Link), peer support services, employment services, supportive living capability, and uniform screening and assessment for substance use disorders.

- Expand child and adolescent behavioral health services statewide to fill identified gaps in basic services, improve quality management and oversight, and implement a children's behavioral health workforce initiative. Based on a statewide assessment, these base services include regional crisis stabilization units and mobile crisis response teams for children, case management, and psychiatric services.
- Establish an Office of Peer Services and Recovery Supports to facilitate development of peer services and recovery supports and assure that peer support specialists demonstrate that they meet competency requirements through a state certification program.

Developmental Services Investment Priorities

- Collaborate with the Department of Medical Assistance Services (DMAS) to expand waiver capacity, modify existing or create new waivers, and address waiver rate structures.
- Expand developmental services capacity to implement the settlement agreement with the U.S. Department of Justice (DOJ).
- Improve the Department's quality assurance and oversight capacity to identify deficiencies, allow electronic individual-level tracking of incidents and systemic analyses of trends and patterns, and follow-up to assure corrective action plans are implemented.

Systemwide Investment Priorities

- Establish a state certification program with core competency training for case managers to demonstrate that they meet competency and training requirements.
- Implement the clinical treatment/medical records modules of an electronic health record (EHR) at all the state facilities.
- Improve Department quality assurance and improvement processes.

Conclusion: Successful implementation of these strategic initiatives will continue Virginia's progress in advancing a community-focused system of recovery-oriented and person-centered services and supports that promote the highest possible level of participation by individuals receiving behavioral health or developmental services in all aspects of community life including work, school, family, and other meaningful relationships.

Implementation of the plan's initiatives also will support the Governor's expressed intention to achieve a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services. They also will enhance the ability of the services system to perform its core functions in a manner that is effective, efficient, and responsive to the needs of individuals receiving services and their families.

The Department's executive leadership will continue to monitor implementation of the Creating Opportunities strategic initiatives and major agency activities identified in the *Comprehensive State Plan 2012-2018*.

Comprehensive State Plan
2012 - 2018

I. INTRODUCTION

Section 37.2-315 of the C*ode of Virginia* requires the Department of Behavioral Health and Developmental Services (Department) to develop and update biennially a six-year Comprehensive State Plan. The plan must identify the services and supports needs of persons with mental health or substance use disorders or intellectual disability across Virginia; define resource requirements for behavioral health and developmental services; and propose strategies to address these needs. This section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

The Department's initial *Comprehensive State Plan 1985-1990* proposed a "responsible transition" to a community-based system of services. In 1986, the plan was expanded to cover a six-year time frame, with updates corresponding to the Department's biennium budget submissions. These updates continued until 1995, when agency strategic planning efforts replaced the *Comprehensive State Plan1996-2002*. Biennial updates to the Comprehensive State Plan were reinstated in 1997 with the completion of the 1998-2004 Plan.

The Comprehensive State Plan has evolved to serve a number of purposes. The plan:

- Establishes services system priorities and future system directions for the public behavioral health (mental health and substance use disorder) and developmental services system;
- Describes strategic responses to major issues facing the services system;
- Identifies priority service needs;
- Defines resource requirements and proposes initiatives to respond to these requirements; and
- Integrates the agency's strategic and budget planning activities.

The *Comprehensive State Plan 2000-2006* introduced an individualized database to document service needs and characteristics of individuals on community services board (CSB) waiting lists. This biennial survey continues to be used to document community service needs. CSB waiting lists include individuals who have sought but are not receiving CSB services and current recipients of CSB services who are not receiving the types or amounts of services that CSB staff have determined they need. The CSB waiting list database provides demographic and service need information about each individual identified as needing community services or supports. Also included in the database are the CSBs' average wait times for accessing specific types of services and their prevention service priorities.

In addition to CSB waiting list information, the Department maintains state facility "ready for discharge" lists. These include individuals receiving services in state hospitals whose discharges have been delayed due to extraordinary barriers and individuals in state training centers who with their authorized representative have chosen to continue to receive services and supports in the community instead of at a training center.

The *Comprehensive State Plan 2012-2018* focuses on the strategic initiatives described in the Department's *Creating Opportunities: A Plan for Advancing Community-Focuses Services in Virginia* (Creating Opportunities Plan) issued on June 25, 2010. This plan identifies behavioral health and developmental services strategic initiatives and major Department activities to:

- Support the Governor's expressed intentions to achieve a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services;

- Continue progress in advancing the vision of self-determination, empowerment, recovery, resilience, health, and participation by individuals receiving behavioral health and developmental services in all aspects of community life;
- Promote efficient and effective management of services system core functions and responsiveness to the needs of individuals receiving services and their families; and
- Communicate the Department's strategic agenda and priority initiatives to key decision-makers in state government, individuals receiving services and their families, public and private providers, advocates, and other interested stakeholders.

The Creating Opportunities Plan builds on the recommendations of the Department's Integrated Strategic Plan (ISP), which was the product of a two-year strategic planning process that involved hundreds of interested Virginians and provided a framework for transforming Virginia's publicly funded behavioral health and developmental services system.

Comprehensive State Plan 2012-2018 initiatives have been incorporated in the Agency Strategic Plan (ASP) and associated Service Area Plans prepared as part of the 2012-2014 performance budgeting submission to the Virginia Department of Planning and Budget (DPB). Using a uniform structure and cross-agency taxonomy of state programs and activities provided by DPB, the Department's ASP aligns the Department's vision, goals, services, objectives, and resource plans with the guiding principles, long-term vision, and statewide objectives established by the Council for Virginia's Future. The Council was established by §2.2-2684 of the *Code of Virginia* to advise the Governor and the General Assembly on implementation of the Roadmap for Virginia's Future process.

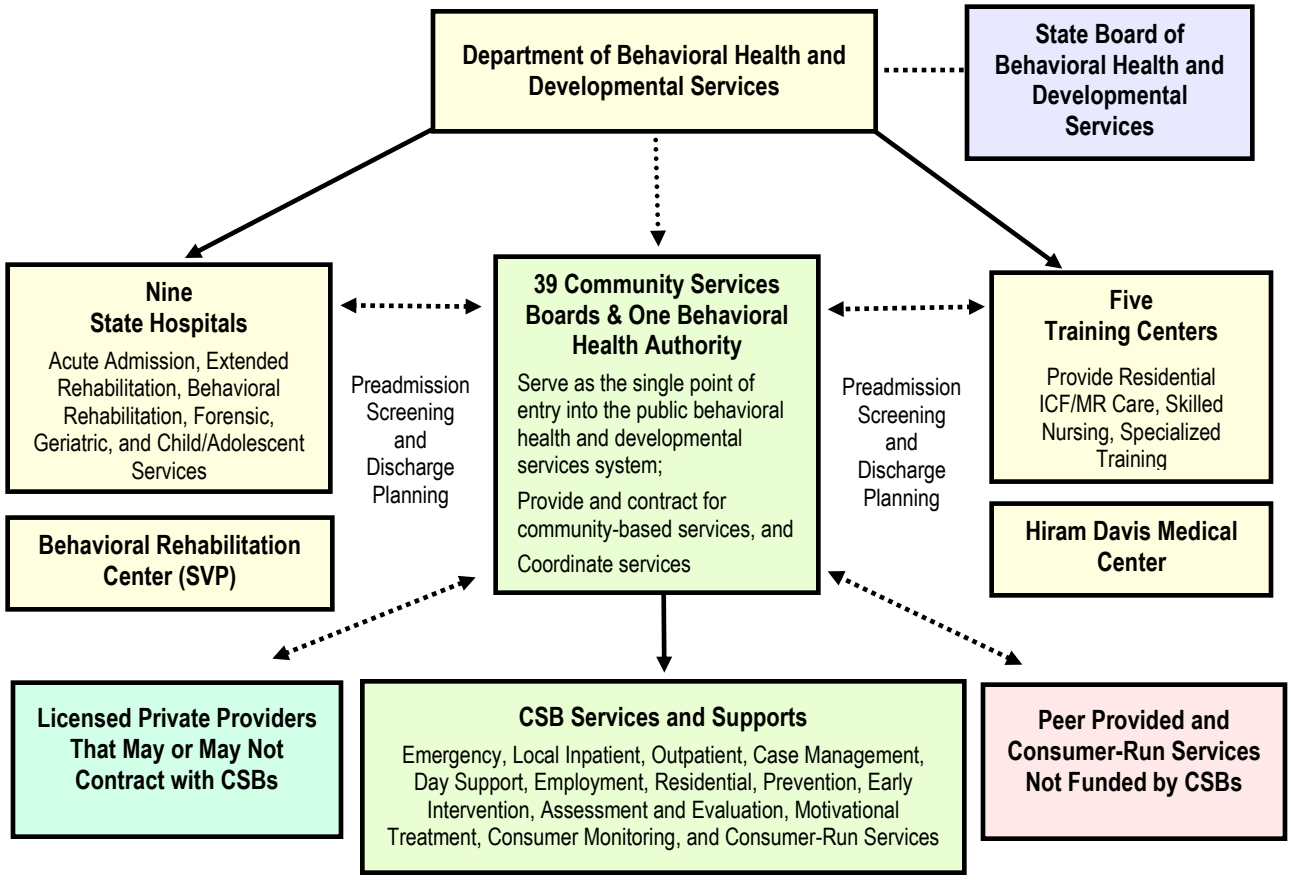
The draft *Comprehensive State Plan 2012-2018* was placed on the Department's website for public review and comment on October 6, 2011. Copies also were provided to individuals upon request. On November 9, 2011, the State Board of Behavioral Health and Developmental Services (State Board) and Department staff conducted a video conference public hearing at four sites to receive public comment on the draft Plan. No comments were received. The Department received nine comments by mail or email. At its December 6, 2011 meeting, the State Board reviewed these comments and considered changes proposed by the Department in response to this public comment.

II. SERVICES SYSTEM OVERVIEW

Services System Structure and Statutory Authority

The public behavioral health and developmental services system in Virginia includes the Department; a state policy board appointed by the Governor; nine state hospitals, five training centers, a medical center, and a behavioral rehabilitation center for sexually violent predators (SVP) operated by the Department; and 39 community services boards and one behavioral health authority (referred to as CSBs) that provide services directly or through contracts with private providers. Maps of CSB service areas and the locations of state facilities are contained in Appendix A.

The following diagram illustrates the relationships among these services system components. Solid lines depict a direct operational relationship between the involved entities (e.g., the Department operates state facilities). Broken lines represent non-operational relationships (e.g., policy direction, contract or affiliation agreement, or coordination).



Title 37.2 of the *Code of Virginia* establishes the Department as the state authority for the Commonwealth's publicly-funded behavioral health (BH) and developmental (DV) services system. By statute, the State Board provides policy direction for Virginia's services system. Descriptions of populations receiving BH or DV services are provided in Appendix B.

The mission of the Department's central office is to provide leadership and service to improve Virginia's system of quality treatment and prevention services and supports for individuals and families whose lives are affected by mental health or substance use disorders or intellectual disability. The central office seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, and the central office and effective relationships with other agencies and providers;
- Providing services and supports in state hospitals (civil and forensic) and training centers;
- Supporting the provision of accessible and effective behavioral health and developmental services and supports provided by CSBs and other providers;
- Assuring that public and private providers of behavioral health or developmental services and supports adhere to licensing standards; and
- Protecting the human rights of individuals receiving behavioral health or developmental services.

Characteristics of Community Services Boards and Trends

Community services boards (CSBs) are established by the 134 local governments in Virginia pursuant to Chapters 5 or 6 of Title 37.2 of the *Code of Virginia* and may serve single or multiple jurisdictions. CSBs provide services directly and through contracts with private providers, which are vital partners in delivering behavioral health and developmental services. CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services, and discharge planning for individuals leaving state facilities. CSBs advocate for individuals who are receiving services or who are in need of services, act as community educators, organizers, and planners, and advise their local governments about behavioral health and developmental services and needs.

Section 37.2-100 of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with local government departments. Chapter 6 in Title 37.2 of the *Code* authorizes certain localities to establish behavioral health authorities (BHAs). In this Plan, CSB or community services board means CSB, BHA, and local government department with a policy-advisory board. Numbers of CSBs that function as local government departments (LGDs) and that serve single or multiple jurisdictions by CSB classification follow:

Combined Classification of Community Services Boards

CSB Classification	Functions as LGD	Cities and/or Counties Served		Total CSBs
		One	Two or More	
Administrative Policy CSBs[1]	7	7	3	10
LGD with Policy-Advisory CSB	1	1	0	1
Operating CSB[2]	0	2	26	28
Behavioral Health Authority[2]	0	1	0	1
TOTAL CSBs	8	11	29	40

[1] Seven of these CSBs are city or county departments; even though 3 CSBs are not, all use local government employees to staff the CSB and deliver services.

[2] Employees in these 28 CSBs and in the BHA are board rather than local government positions.

While not part of the Department, CSBs are key operational partners with the Department and its state facilities in Virginia's public behavioral health and developmental services system. The Department's relationships with all CSBs are based on the community services performance contract, provisions of Title 37.2 of the *Code of Virginia*, State Board policies and regulations, and other applicable state or federal statutes or regulations. The Department contracts with, provides consultation to, funds, monitors, licenses, and regulates CSBs. More information about CSBs is available in the *Overview of Community Services in Virginia* at www.dbhds.virginia.gov/documents/OCC-CSB-Overview.pdf.

CSB Mental Health Services

In FY 2011, 107,892 individuals received CSB mental health (MH) services. This represents an unduplicated count of all individuals receiving any MH services.

Number of Individuals Receiving Mental Health Core Services in FY 2011

Core Service	# Served	Core Service	# Served
Local Inpatient Services	**2,229**	Group Supported Employment	17
Outpatient Services	88,792	**TOTAL Employment Services**	**1,180**
Intensive Community Treatment	1,902	Highly Intensive Residential	67
TOTAL Outpatient Services	**90,694**	Residential Crisis Stabilization	4,046
Case Management Services	**55,674**	Intensive Residential	233
Day Treatment/Partial Hospitalization	5,149	Supervised Residential	1,137
Ambulatory Crisis Stabilization Services	1,649	Supportive Residential	6,699
Rehabilitation Services	5,426	**TOTAL Residential Services**	**12,182**
TOTAL Day Support Services	**11,114**	**TOTAL Individuals Served**	**173,073**
Sheltered Employment Services	43	**TOTAL Unduplicated Individuals**	**107,892**
Supported Employment	1,120		

Source: FY 2011 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2011, the numbers of individuals receiving various CSB mental health services grew from 135,182 to 173,073 (28 percent). In FY 2008, the Department created a new Services Available Outside of a Program Area that includes Emergency, Motivational Treatment, Consumer Monitoring, Early Intervention, and Assessment and Evaluation Services and Consumer-Run Programs and that were previously classified separately by program area. Between FY 2008 and FY 2011, the unduplicated number of individuals receiving CSB MH services increased from 101,796 to 107,892 (six percent).

In FY 2011, of the 76,630 adults receiving mental health services, 45,963 adults (60 percent) had a serious mental illness and of the 31,225 children receiving services, 23,584 (75.5 percent) had or were at risk of having a serious emotional disturbance.

CSB Developmental Services

In FY 2011, 20,387 individuals received CSB developmental (DV) services. This represents an unduplicated count of all individuals receiving any DV services.

Number of Individuals Receiving Developmental Core Services in FY 2011

Core Service	# Served	Core Service	# Served
Outpatient Services	**654**	Highly Intensive Residential	159
Case Management Services	**18,294**	Intensive Residential	856
Rehabilitation or Habilitation	2,619	Supervised Residential	482
TOTAL Day Support Services	**2,619**	Supportive Residential	1,189
Sheltered Employment Services	827	**TOTAL Residential Services**	**2,686**
Transitional or Supported Employment	1,081	**TOTAL Individuals Served**	**26,912**
Group Supported Employment	751	**TOTAL Unduplicated Individuals**	**20,387**
TOTAL Employment Services	**2,659**		

Source: 2011 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 and FY 2011, the numbers of individuals receiving various CSB developmental services increased from 20,329 to 26,912 or by three percent.

CSB Substance Abuse Services

In FY 2011, 36,769 individuals received substance abuse (SA) services from CSBs. This represents an unduplicated count of all individuals receiving any SA services.

Number of Individuals Receiving Substance Abuse Core Services in FY 2011

Core Service	# Served	Core Service	# Served
Local Inpatient	106	Highly Intensive Residential Services	3,238
Community-Based SA Medical Detox Inpatient	236	Residential Crisis Stabilization Services	336
TOTAL Local Inpatient Services	**342**	Intensive Residential Services	3,523
Outpatient Services	28,445	Supervised Residential Services	300
Medication Assisted Treatment	1,874	Supportive Residential Services	101
TOTAL Outpatient Services	**30,319**	**TOTAL Residential Services**	**7,498**
Case Management Services	**10,220**	**TOTAL Individuals Served**	**48,964**
Day Treatment/Partial Hospitalization	585	**TOTAL Unduplicated Individuals**	**36,769**
TOTAL Day Support Services	**585**		

Source: 2011 Community Services Performance Contract Annual Reports, Department.

Between FY 1986 and FY 2011, the numbers of individuals receiving various CSB substance abuse services declined from 52,942 to 48,964, a decrease of 7.5 percent. In FY 2008, the Department added a new program area, Services Available Outside of a Program Area, which includes Emergency, Motivational Treatment, Consumer Monitoring, Assessment and Evaluation, and Early Intervention Services that has been previously classified separately by program area. Between FY 2008 and FY 2011, the unduplicated number of individuals receiving CSB substance abuse services decreased from 43,657 to 36,769 (16 percent).

CSB Services Available Outside a Program Area

In FY 2011, 86,881 unduplicated individuals received CSB services available outside a program area. Additionally, 5,979 individuals received services in a Consumer-Run Program.

Number of Individuals Receiving Services Available Outside a Program Area in FY 2011

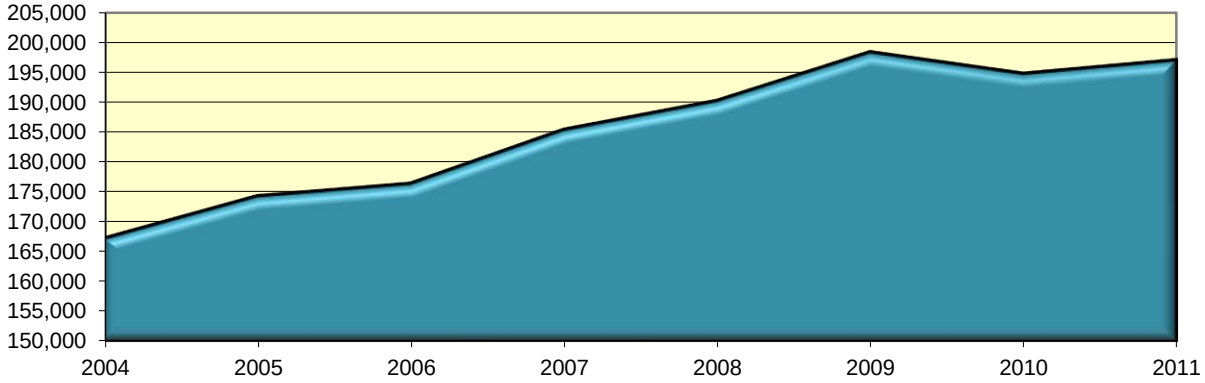
Core Service	# Served	Core Service	# Served
Emergency Services	58,553	Assessment and Evaluation	28,731
Motivational Treatment	2,001	Early Intervention Services	2,609
Consumer Monitoring Services	5,882	**TOTAL Individuals Served**	**97,776**
		TOTAL Individuals (Unduplicated)	**86,881**

Source: 2011 Community Services Performance Contract Annual Reports, Department.

Unduplicated Count of Individuals Receiving CSB Services

With the implementation in FY 2004 of the Community Consumer Submission (software that extracts and transmits encrypted data from CSB information systems to the Department), a totally unduplicated count of individuals receiving CSB services across all program areas became available for the first time. In FY 2011, the total unduplicated count of individuals served was 196,951.

Trends in Unduplicated Numbers of Individuals Receiving CSB Services FY 2004 - FY 2011



The decline in the reported number of unduplicated individuals served is due to the reduction in the number of individuals receiving substance abuse services and Part C infants and toddler services being reported separately. In FYs 2010 and 2011, 12,173 and 14,069 infant and children, respectively, were served by the Part C network. Thirty of the 40 local lead agencies providing Part C services are CSBs.

Appendix C contains detailed information on CSB service utilization trends for individuals served and services provided by CSBs in FY 2011. Core services definitions are available at (www.dbhds.virginia.gov./documents/reports/OCC-2010-CoreServicesTaxonomy7-2v2.pdf).

Characteristics of State Hospitals and Training Centers and Trends

State Hospitals

The Department operates eight state hospitals for adults: Catawba Hospital (CH) in Salem, Central State Hospital (CSH) in Petersburg, Eastern State Hospital (ESH) in Williamsburg, Piedmont Geriatric Hospital (PGH) in Burkeville, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton. The Department also operates the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, the only state hospital for children with serious emotional disturbance.

State hospitals provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided to older adults, children and adolescents, and individuals with a forensic status. October 2011 operating (staffed) bed capacities and FY 2011 average daily census (ADC) for the state hospitals follow.

State Hospital Operating Capacities and FY 2011 Average Daily Census

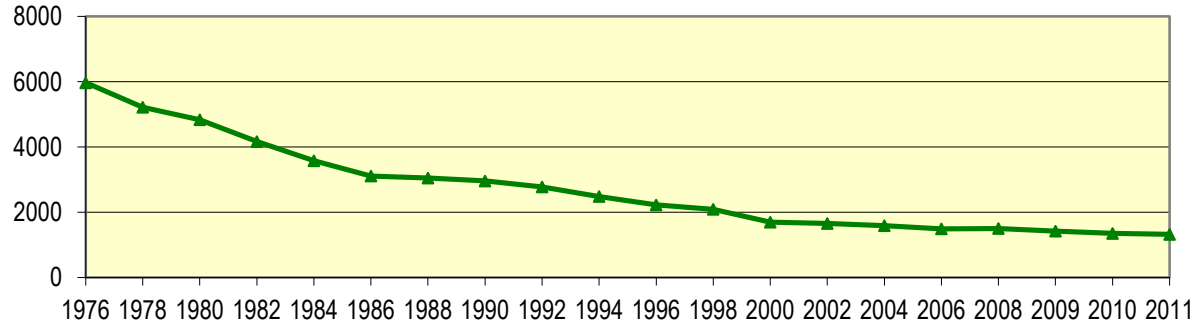
MH Facility	Beds	ADC	MH Facility	Beds	ADC
Catawba Hospital	120	100	Piedmont Geriatric	135	110
Central State Hospital	277	232	Southern VA MHI	96	71
CCCA	48	35	Southwestern VA MHI	156	140
Eastern State Hospital	306	289	Western State Hospital	253	227
Northern VA. MHI	123	115	Total Operating Capacity (Beds) and ADC	**1,514**	**1,319**

Note: HDMC, with an operating capacity of 87 beds and an ADC of 58 and VCBR, with an operating capacity of 300 beds and an ADC of 239 are not included in this table.

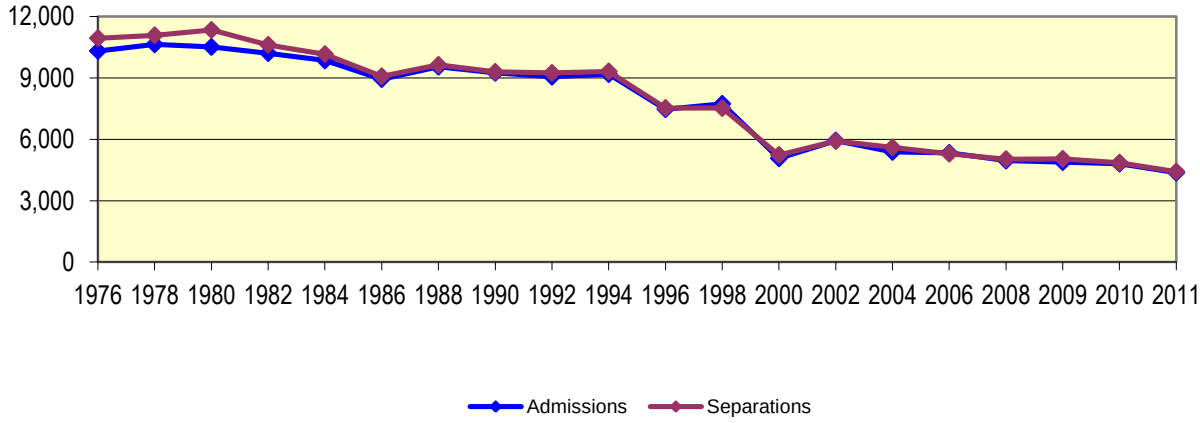
The Department also operates Hiram Davis Medical Center (HDMC) in Petersburg to provide medical services for patients and the Virginia Center for Behavioral Rehabilitation (VCBR) in Burkeville to provide treatment of sexually violent predators.

Between FY 1976 and FY 2011, the average daily census at state hospitals, excluding HDMC and VCBR, declined by 4,648 or 77 percent (from 5,967 to 1,319). Admissions, excluding the HDMC and VCBR, declined by 58 percent (from 10,319 to 4,366) and separations (discharges) declined by 60 percent (from 10,943 to 4,421). In FY 2011, VCBR experienced 80 admissions and 21 separations.

Trends in State Hospital Average Daily Census (ADC) FY 1976 - FY 2011



Trends in State Hospital Admissions and Separations FY 1976 - FY 2011



Note: Includes the Virginia Treatment Center for Children through FY 1991, when it transferred to the Medical College of Virginia.

Training Centers

The Department operates five training centers to serve individuals with intellectual disability: Central Virginia Training Center (CVTC) in Lynchburg, Northern Virginia Training Center (NVTC) in Fairfax, Southside Virginia Training Center (SVTC) in Petersburg, Southeastern Virginia Training Center (SEVTC) in Chesapeake, and Southwestern Virginia Training Center (SWVTC) in Hillsville. Training centers provide highly structured habilitation services, including residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development for individuals with intellectual disability.

All training centers are certified by the U.S. Centers for Medicare and Medicaid as meeting Medicaid Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID) standards of quality. CVTC also provides skilled nursing services. In addition, CVTC provides skilled

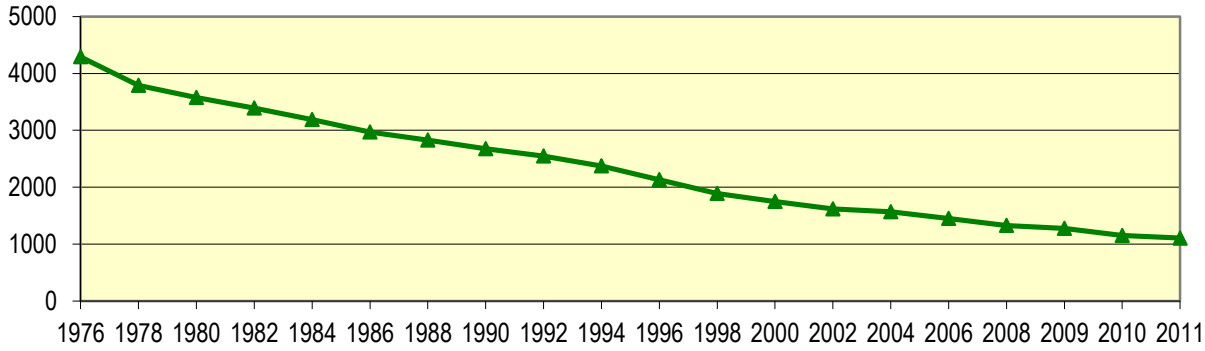
nursing services. October 2011 operating (staffed) bed capacities and FY 2011 average daily census (ADC) for each training center follow.

Training Center Operating Capacities and FY 2011 Average Daily Census

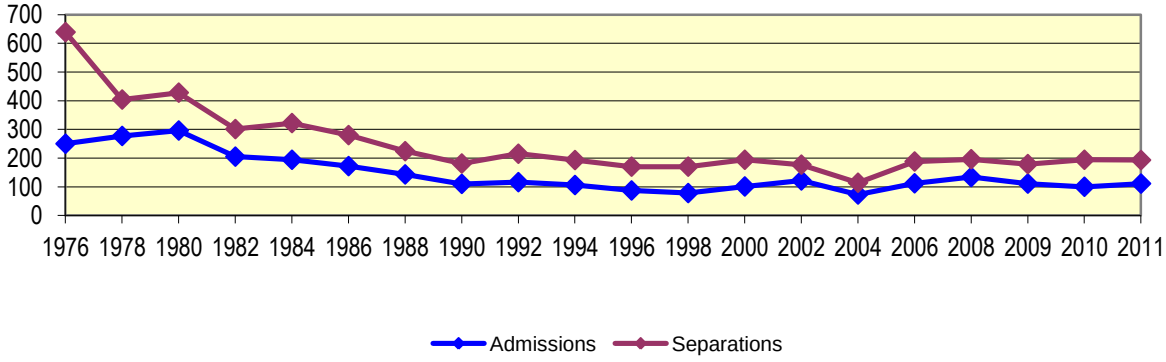
Training Center	Beds	ADC	Training Center	Beds	ADC
Central Virginia Training Center	461	393	Southside Virginia Training Center	307	246
Northern Virginia Training Center	176	157	Southwestern Virginia Training Center	202	182
Southeastern Virginia Training Center	200	126	Total Operating Capacity (Beds) and ADC	**1,346**	**1,104**

Between FY 1976 and FY 2011, the average daily census at training centers declined by 3,189 or 74 percent (from 4,293 to 1,104). Training center admissions decreased by 56 percent (from 250 to 111) and separations (discharges) decreased by 70 percent (from 639 to 193).

Trends in Training Center Average Daily Census (ADC) FY 1976 - FY 2011



Trends in Training Center Admissions and Separations FY 1976 - FY 2011



Profile of Individuals Receiving Services and Supports in State Facilities

In FY 2011, 6,338 individuals were served in state facilities. Of these, 4,779 unduplicated individuals received 5,730 episodes of care in state hospitals; 1,226 unduplicated individuals received 1,276 episodes of care in training centers, and 295 unduplicated individuals were served at VCBR. In general, the individuals served in state facilities are white (62 percent), male (63 percent), between 18 and 64 years of age (79 percent), and receiving mental health support services (75 percent).

The average age of individuals served in training centers was 50 years of age and their average length of stay was 30 years, with four percent of the episodes of care (49) being less than seven days and 12 percent (149) being more than 50 years.

During FY 2011, 80 individuals were admitted to VCBR and 21 individuals were discharged. All of the individuals were male and 97 percent were between 21 to 64 years of age.

Appendix D contains detailed information on state facility utilization, including the numbers served, average daily census, admissions, separations, and utilization by CSB.

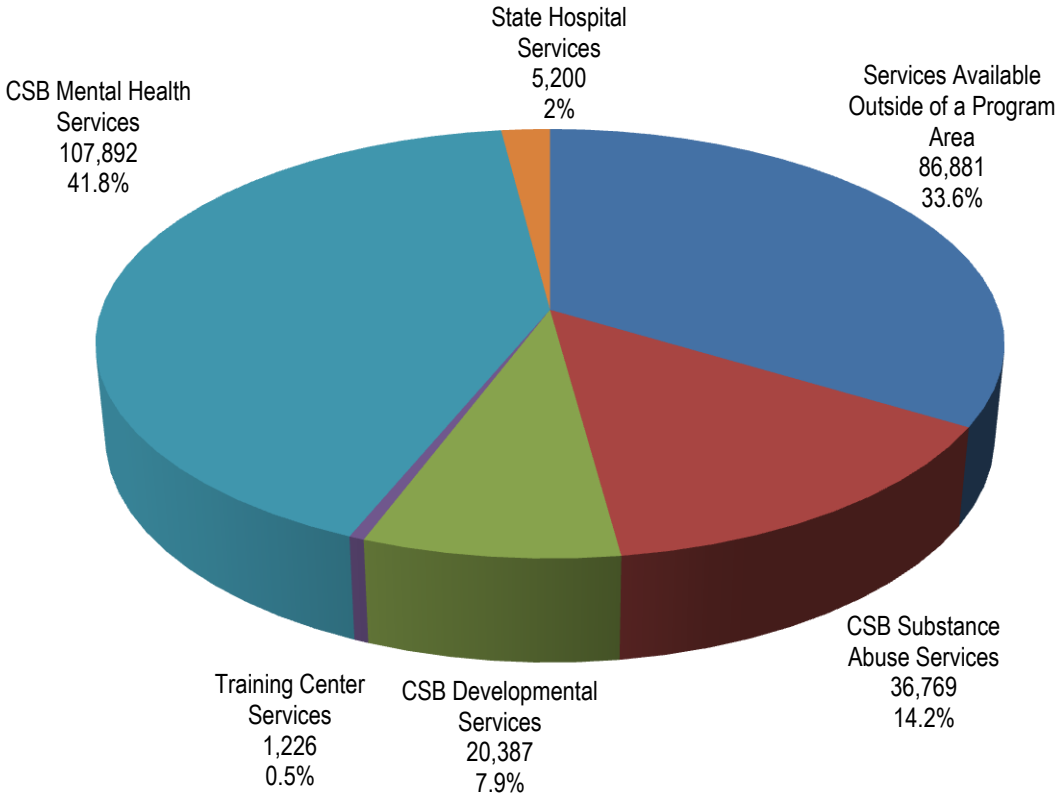
Unduplicated Count of Individuals Receiving Public Behavioral Health and Developmental Services

In FY 2011, 203,377 individuals received services in the public behavioral health and developmental services system through CSBs, which served 196,951 individuals, or state facilities, which served 6,426 individuals. These figures are unduplicated within each CSB or state facility, but they are not unduplicated:

- Across CSBs, that is, a person may receive services from more than one CSB;
- Between state facilities, that is, a person may receive services from more than one state hospital or training center; or
- Between CSBs and state facilities.

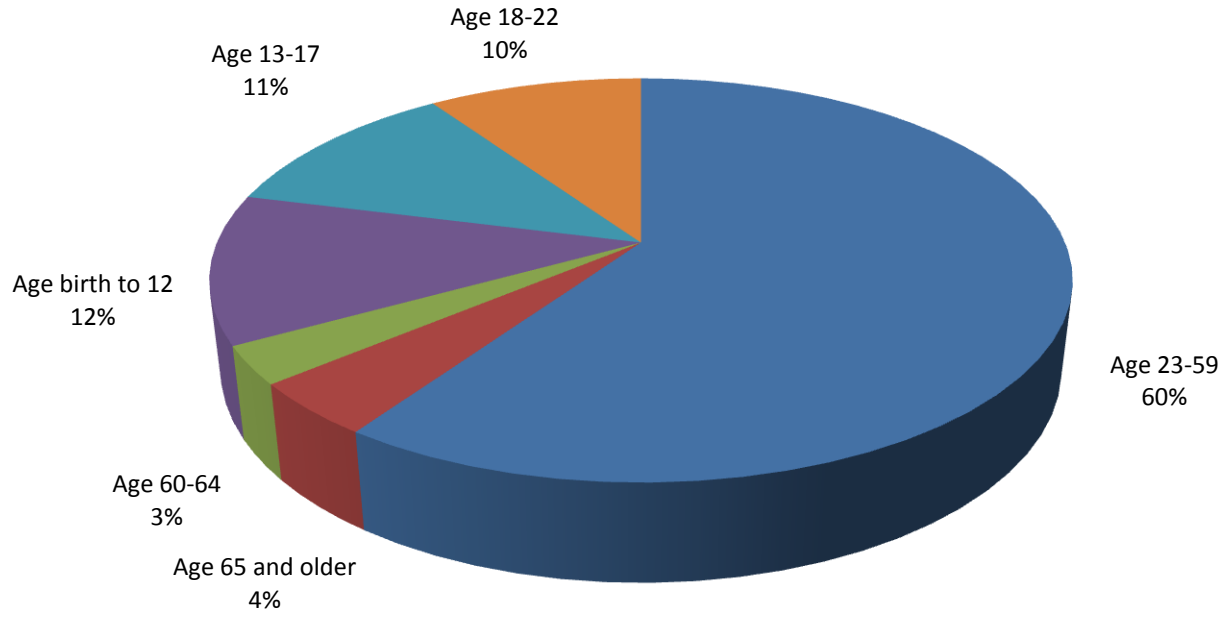
The pie charts below depict the numbers, age distribution, and racial distribution of individuals receiving services from CSBs or state facilities in FY 2011. These charts do not include individuals receiving Part C infant and toddler services.

Individuals Receiving Services From CSBs and State Facilities

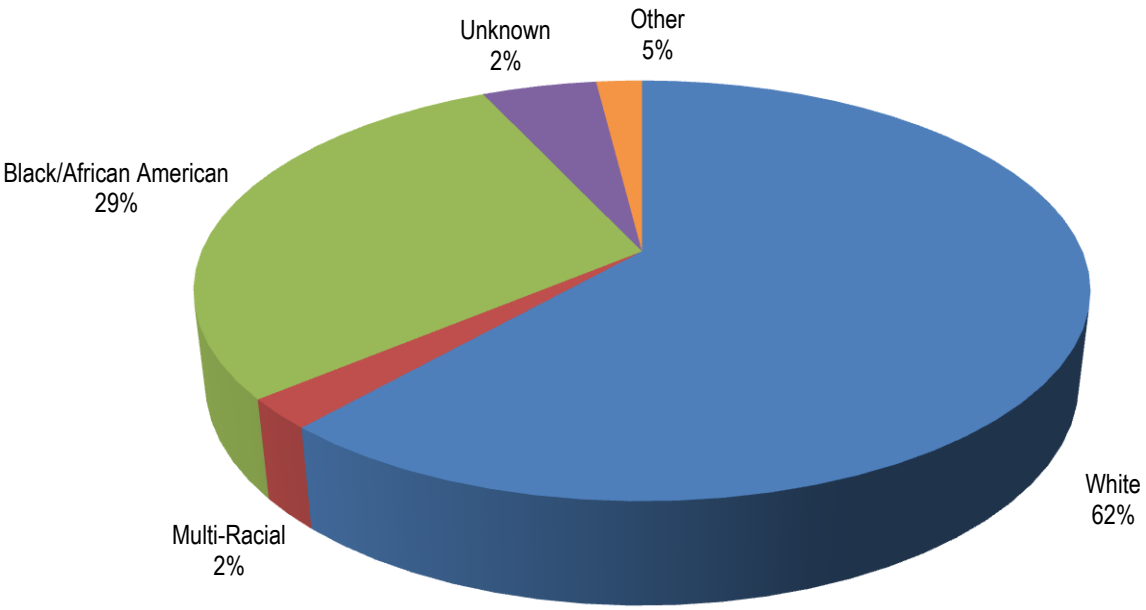


The number of individuals now receiving Medicaid Intellectual Disability Home and Community-Based Waiver (ID waiver) services totals 8,486. This chart includes 3,580 individuals who received these services from CSBs in FY 2011. Also included are 2,571 individuals who received acute, short term mental health inpatient psychiatric services through local inpatient purchase of services funding in their communities.

Age Distribution of Individuals Receiving CSB and State Facility Services



Racial Distribution of Individuals Receiving CSB and State Facility Services



* The Other category above includes American Indian, Alaskan Native, and Other Racial categories

The racial diversity of the population served by CSBs is greater than that of the state facilities, with 7.4 percent of the population served by CSBs classified as Other Racial or Multi-Racial compared to 2.5 percent of individuals served in state facilities.

The number and percentage of individuals served who are identified as being of Hispanic origin is higher in the community; with CSBs serving 10,838 (5.5 percent) individuals and the facilities serving 162 (2.6 percent) individuals. According to the 2010 Census, 7.9 percent of Virginia's population is of Hispanic origin.

Licensed Providers of Behavioral Health or Developmental Services

In FY 2011, the Department licensed 736 providers of behavioral health, developmental, developmental disability waiver, and residential brain injury services. This included 131 licenses issued to new providers. Licensed providers must meet and adhere to regulatory standards of health, safety, service provision, and individual rights.

Services System Partnerships

State Level Partnerships

The Department continues to strengthen its partnerships with many state agencies and other organizations that are involved in the provision of services and supports to or interact with individuals with mental health or substance use disorders, intellectual or other developmental disabilities, or co-occurring disorders. These partnerships help to raise awareness of the needs and challenges of individuals receiving behavioral health and developmental services, provide opportunities for coordinating state-level policy direction and guidance to local services systems, and support statewide and community-based initiatives that promote access to and continuity of needed services and supports.

Medicaid: Medicaid is the largest single source of funds for community behavioral health and developmental services. The Department and the Department of Medical Assistance Services (DMAS) work closely in policy development, provider expansion, provider education and training, development of quality assurance measures, and provider oversight. Additionally, the Department and DMAS are working with other state agencies and private organizations to implement a Money Follows the Person Demonstration grant, which provides enhanced federal Medicaid matching funds for a 12 month period to individuals with disabilities transitioning from institutions to community residences of four beds or less.

Social Services: The Department and the Department of Social Services (DSS) collaborate through a variety of programs and services to help individuals cope with and recover from the effects of poverty, abuse, or neglect and achieve self-sufficiency. This includes services to families who are TANF recipients, to families confronting child custody issues, and to substance-exposed infants and their families.

Housing: The Department has collaborative partnerships with the Virginia Housing Development Authority (VHDA) and Department of Housing and Community Development (DHCD) to promote, enhance, and develop housing opportunities for individuals receiving behavioral health services. The Department also works with the Virginia Coalition to End Homelessness and supports PATH outreach and engagement activities for individuals who are homeless and recovery-focused housing alternatives, such as Oxford Houses, for individuals with substance use disorders.

Primary Health Care: There are a number of published studies showing that individuals with serious mental health disorders have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. Physical health care is considered a core component of basic services for individuals with behavioral health disorders although this care is often fragmented for these individuals. The Department maintains partnerships with appropriate agencies and entities, including the Virginia Department of Health (VDH), Department of Health Professions (DHP), the Virginia Community Healthcare Association, Virginia Rural Health Resource Center, Virginia Hospital and Healthcare Association, Virginia College of Emergency Physicians, and Virginia Association of Free Clinics.

Employment Services and Supports: Individuals with mental health or substance use disorders, intellectual or other developmental disabilities, or co-occurring disorders face challenging obstacles to obtaining and maintaining competitive employment. Mental health and substance abuse employment initiatives between the Department and the Department of Rehabilitative Services (DRS) provide specialized vocational assistance services in CSBs. A

multi-agency initiative involving the Department, DRS, DMAS, and the academic community has further developed Virginia-specific WorkWORLD™ software to support people with disabilities who are making decisions about gainful work activity and the use of work incentives. The Department supports use of this software to expand training on Social Security work incentives and other benefits counseling.

***Criminal Justice and Juvenile Justice Service*s:** In too many cases, the criminal justice system has become the primary source for behavioral health care. The Department works with the Department of Corrections (DOC), Department of Juvenile Justice (DJJ), and Department of Criminal Justice Services (DCJS) in ongoing efforts to improve screening, ensure appropriate treatment and supports, and enhance interagency planning and coordination to better meet the needs of individuals involved with the criminal justice system. This includes support for jail diversion programs such as Crisis Intervention Teams (CIT) and CSB provision of short-term behavioral health services in jails and juvenile detention centers. The Department and DOC work closely to improve access to hospital and community treatment resources for inmates who have been released from DOC facilities and to screen inmates who are potentially appropriate for civil commitment to the Department as sexually violent predators. DCJS and the Department have jointly provided training in behavioral health evaluation and treatment methods for law enforcement personnel, including jail security staff.

Education: The Department partners with the Department of Education (DOE) to support collaborative activities between schools and the behavioral health and developmental services system. For children birth to three, the Department is the lead agency for services under Part C of the Individuals with Disabilities Education Act. DOE is involved with all state initiatives focused on Part C services, including the state Virginia Interagency Coordinating Council for Part C. For the school age population, the Department and DOE work closely on a variety of interagency initiatives to improve in-school support for children with behavioral health problems and improve outcomes for Virginia's children. This includes intensive efforts to keep children in their homes and community schools.

Advocacy: The Department central office and state facilities work cooperatively with the Virginia Office for Protection and Advocacy (VOPA) to protect and advocate for the human and legal rights of individuals receiving behavioral health or developmental services. Section 51.5-37.1 of the *Code of Virginia* requires the Department to report all deaths and critical incidents to the VOPA within 48 hours of occurrence or discovery and provide follow-up reports.

Local Interagency and Regional Planning Partnerships

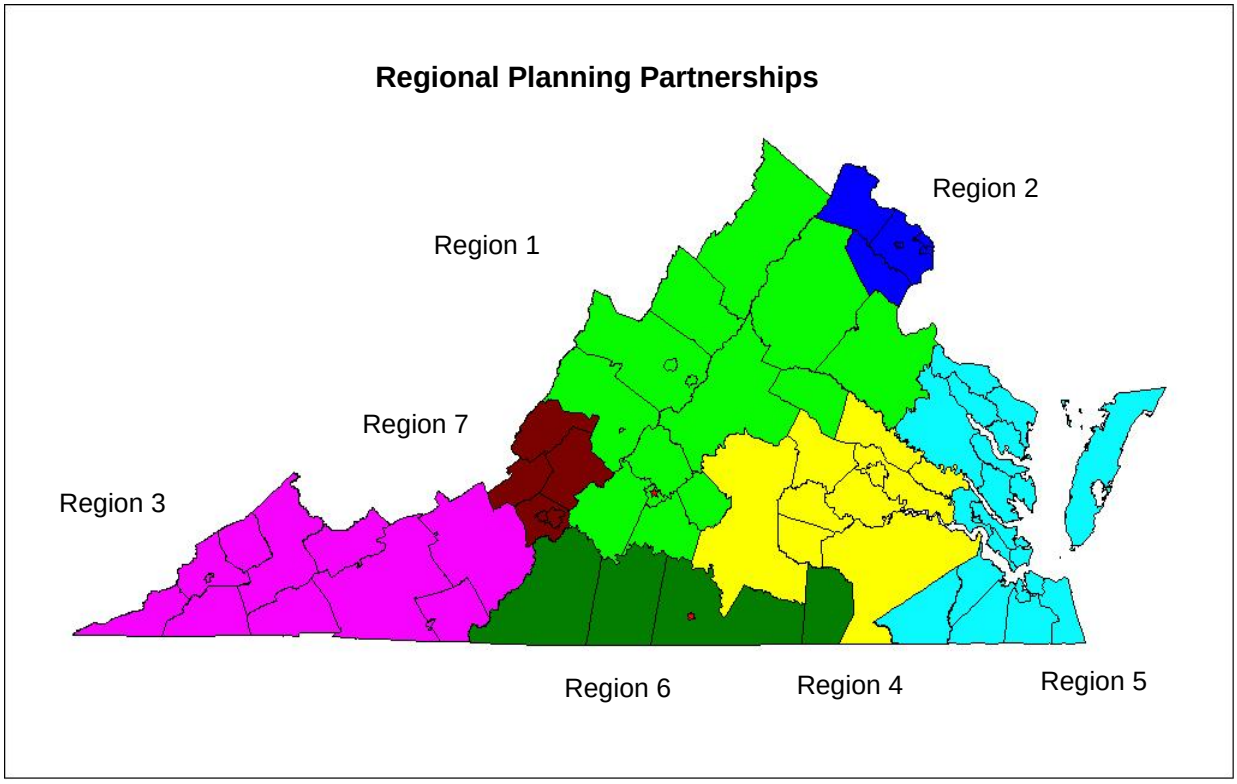
The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community behavioral health and developmental services to more than 190,000 Virginians annually. Local governments partner with the Department through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs.

At the local level, CSBs maintain critical interagency partnerships with local agencies, including school systems, social services, local health departments, and area agencies on aging. Services provided by these local agencies include auxiliary grants for assisted living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance, and services for TANF recipients. Local agencies also may participate on Part C local interagency coordinating councils and provide Part C services to infants and toddlers.

Seven regional partnerships have been established to facilitate regional planning for services system transformation and promote regional utilization management. These partnerships provide forums to address regional challenges and service needs and collaboratively plan and implement regional initiatives. Partnership participants include CSBs, state facilities, community inpatient psychiatric hospitals and other private providers, individuals receiving services, family

members, advocates, and other stakeholders. Each regional partnership has established a regional utilization review team or committee to manage the region's use of inpatient beds.

The following map depicts the seven regional partnership areas.



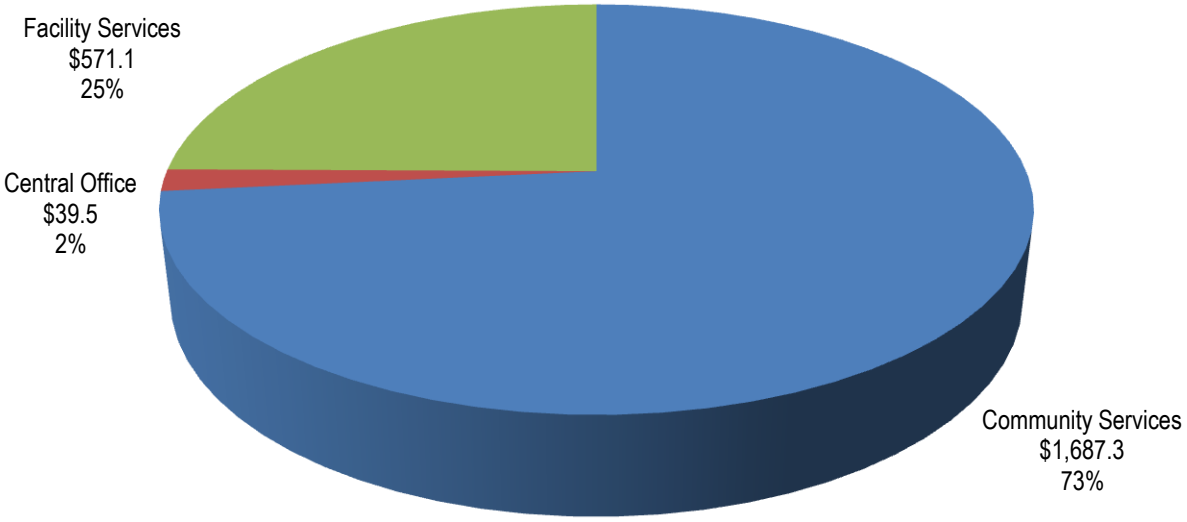
Partnerships with Private Providers

Private provider participation is another major strength of the public behavioral health and developmental services system. This participation has grown dramatically over the last six years. The private sector is a vital partner with CSBs in serving people with mental health or substance use disorders, intellectual disability, or co-occurring disorders. For example, many local private psychiatric hospitals or hospitals with psychiatric units provide acute inpatient psychiatric services purchased by CSBs for individuals receiving CSB services. In addition to serving many individuals through contracts with CSBs, private providers also serve other individuals directly, for example, through various Medicaid programs such as the ID waiver (with plans of care managed by CSBs). The continued expansion of waiver services and some Medicaid rehabilitation services have been major factors influencing this growth. Also, local private psychiatric hospitals and hospital emergency departments often serve as the front line in the delivery of emergency response services to individuals with mental health or substance use disorders or intellectual disability.

Services System Funding and Trends

Charts depicting the services system's total resources in the public behavioral health and developmental services system for **FY 2011** from **ALL SOURCES** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid payments to private vendors, follow.

Total FY 2011 Behavioral Health and Developmental Services System Funding: $2.298 Billion

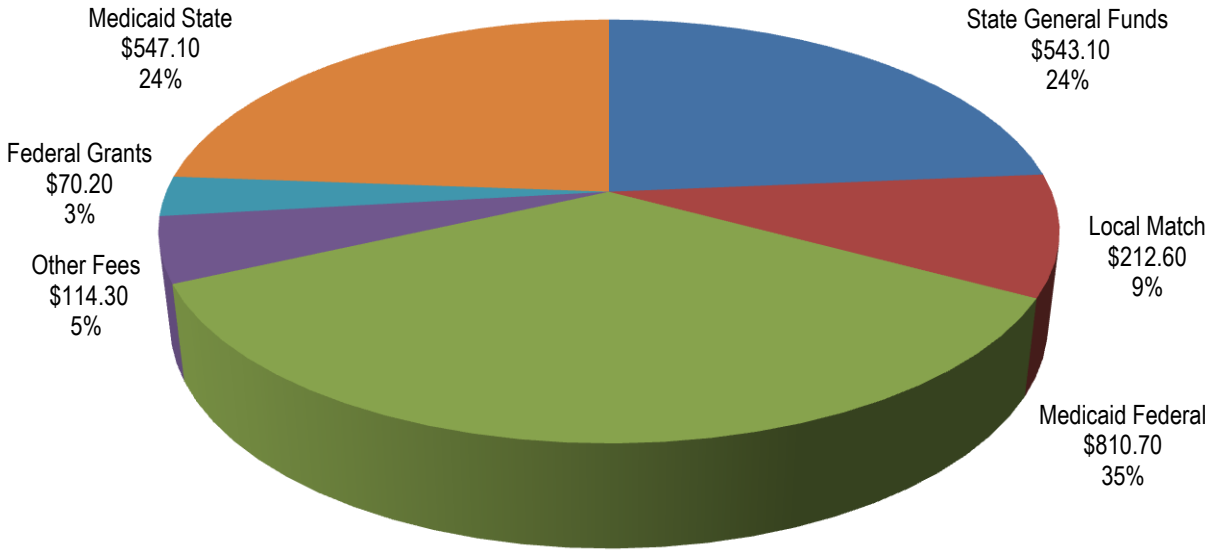


Community services funding includes CSB expenditures and private providers of Medicaid funds for community services. CSB funding includes state general funds, federal funds, local government appropriations, charitable donations, in-kind contributions, and fees. The overwhelming share of local funds is provided by the 134 cities or counties that established the 40 CSBs. Fees include Medicaid, Medicare, and private insurance reimbursements and payments from individuals receiving services. Other funds include workshop sales, retained earnings, and one-time funds.

State facility funding includes state general funds, federal funds, Medicaid, Medicare, commercial insurance, private payments, MH Commitment Fund, and other revenues.

The Department's central office funding includes state general funds, federal funds, and special funds.

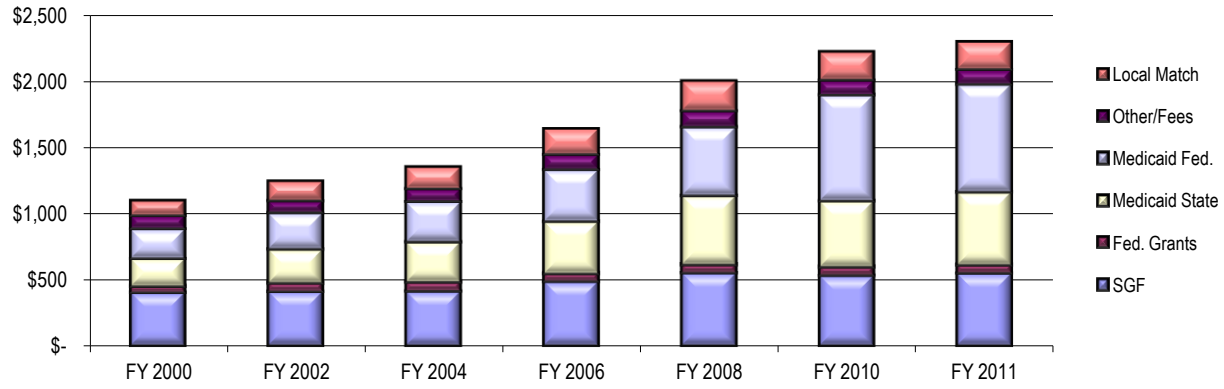
Total FY 2011 Behavioral Health and Developmental Services System Funding by Fund Source: $2.298 Billion



Total Services System Funding Trends by Funding Source

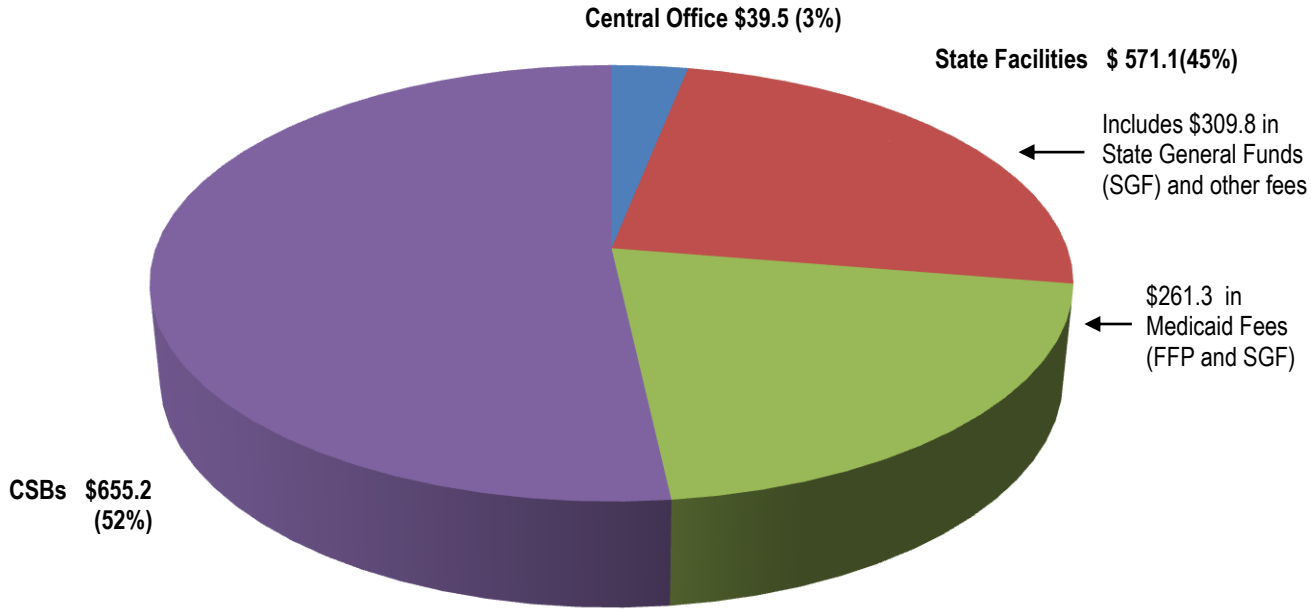
FY 2000 – FY 2011

	FY 2000	FY 2002	FY 2004	FY 2006	FY 2008	FY 2010	FY 2011
State General Funds	399.9	408.2	408.7	482.4	544.9	526.6	543.1
Federal Grants	56.2	72.2	78.7	68.5	70.0	70.7	70.2
Medicaid - State	209.0	256.9	302.1	390.9	518.6	497.0	547.1
Medicaid - Federal	223.2	273.3	303.7	390.9	518.6	797.0	810.7
Other/Fees	102.0	92.8	99.0	115.8	124.1	115.8	114.3
Local Match	115.9	149.3	166.2	196.2	227.6	214.5	212.6
Total	$1,106.2	$1,252.7	$1,358.4	$1,644.8	$2,004.0	$2,221.6	$2,298.0



FY 2011 Public Behavioral Health and Developmental Services System Expenditures*

Funding: $1.2658 Billion



* Does not include $747.7million in private provider Medicaid fees

Dollars in charts and table above are in millions

III. PREVALENCE ESTIMATES

When planning for needed behavioral health and developmental services, it is important to have a sense of how many individuals could potentially need care. This section uses national epidemiological studies to extrapolate the prevalence in Virginia of adults with serious mental illnesses, children and adolescents with serious emotional disturbance, individuals with intellectual disability or developmental disability, and individuals with substance use disorders. The source of Virginia population counts for the following estimates is the 2010 DP1 Profile of General Demographic Characteristics, U.S. Census Bureau.

Only a portion of these individuals will seek services from the public behavioral health and developmental services system. Some will not seek services and others will be served by private providers.

Estimated Prevalence for Adults with Serious Mental Illnesses: Using Virginia results from the 2008 and 2009 Substance Abuse and Mental Health Services Administration (SAMHSA) National Surveys on Drug Use and Health (NSDUHs), 239,747 (3.9 percent) of Virginia adults have a serious mental illness.

Estimated Prevalence for Children and Adolescents With Serious Emotional Disturbance: Using the methodology published by CMS in the Federal Register, Volume 63, No. 137, Friday, July 17, 1998, between 84,978 and 103,861 Virginia children and adolescents (ages 9-17) have a serious emotional disturbance (level of functioning score of 60) and between 47,210 and 66,094 have serious emotional disturbance with extreme impairment (level of functioning score of 50).

Estimated Prevalence for Individuals with Intellectual Disability: National research on the prevalence of intellectual disability range from 1 and 3 percent of the population over age 6 (Arc of the United States, October 2004). A conservative approximation (using a 1 percent rate) estimates that 73,890 individuals age 6 and over in Virginia have intellectual disability.

Estimated Prevalence for Individuals with Developmental Disabilities: Using the 1.8 percent rated recommended by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Administration on Developmental Disabilities (ADD) to state DD Councils, 144,018 Virginians may have a developmental disability. Recent estimates by the CDC's National Center for Health Statistics are that one in 91 children have an autism spectrum disorder.

Estimated Prevalence for Infants and Toddlers in Need of Early Intervention Services: The Department estimates that 18,427 (3 percent) of Virginia's infants and toddlers are potentially eligible for Part C services. This is based on national and Virginia studies of children with specific diagnoses, estimates of children with delay influenced by Virginia poverty rates, prevalence of low birth weight children, children identified on the hearing registry; children assessed and requiring services in one year, and rates of states with comparable eligibility.

Estimated Prevalence for Individuals with Substance Use Disorders: Using Virginia results from the 2006, 2007 and 2008 NSDUHs, prevalence estimates of substance abuse and dependence in the past year for individuals ages 12 and over from the follow:

- Dependence on or abuse of any illicit drug – 187,669 (2.77 percent) Virginians are dependent on or abuse illicit drugs. Of these 130,081 met the criterion for dependence.
- Dependence on or abuse of alcohol – 517,613 (7.64 percent) Virginians are dependent on or abuse alcohol. Of these 242,547 met the criterion for dependence.

Appendix E provides prevalence estimates for serious mental illness, serious emotional disturbance, intellectual and development disability, and drug and alcohol dependence by CSB.

IV. CURRENT AND FUTURE SERVICE NEEDS

CSB Waiting Lists

Numbers of Individuals on CSB Waiting Lists

To document existing service demands, the Department asked CSBs to complete a point-in-time survey of each person identified by the CSB as being in need of specific services during the first quarter of calendar year 2011. The following table displays the number of individuals who were identified as being on CSB waiting lists.

Numbers of Individuals on CSB Waiting Lists for Mental Health, Developmental, or Substance Abuse Services: January - April 2011

Populations of CSB Waiting Lists	Numbers Receiving Some CSB Services	Numbers Receiving No CSB Services	Total Numbers on CSB Waiting Lists
CSB Mental Health Services Waiting List Count			
Adults	3,187	830	4,017
Children and Adolescents	1,327	372	1,699
Total Waiting for Mental Health Services	4,514	1,202	5,716
CSB Developmental Services Waiting List Count			
Adults	3,327	713	4,040
Children and Adolescents	1,606	769	2,375
Total Waiting for Developmental Services	4,933	1,482	6,415
CSB Substance Abuse Services Waiting List Count			
Adults	1,068	704	1,772
Adolescents	55	46	101
Total Waiting for Substance Abuse Services	1,123	750	1,873
Grand Total on All CSB Services Waiting Lists	**10,570**	**3,434**	**14,004**

This count includes 108 individuals on mental health and substance abuse services waiting lists, 76 individuals on mental health and developmental services waiting lists, and one person on developmental and substance abuse services waiting lists.

To be included on the waiting list for CSB services, an individual had to have sought the service and been assessed by the CSB as needing that service. CSB staff also reviewed their active cases to identify individuals who were not receiving all of the amounts or types of services that they needed. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year. Appendix F depicts numbers of individuals on waiting lists for mental health, developmental, and substance abuse services by CSB.

In August 2011, there were 5,771 individuals on the Statewide Waiting List for ID Waiver Services (3,168 were on the waiver urgent waiting list and 2,603 were on the waiver non-urgent list). CSB developmental services wait lists included 2,625 individuals who were also on the ID waiver urgent waiting list, 1,991 who were on the ID waiver non-urgent list, and 328 who were on CSB ID waiver planning lists. Of the individuals on CSB wait lists for developmental services, 58 had an allocated ID waiver slot but were waiting for waiver services that were not yet available and 423 had an ID waiver slot but also were waiting for services that were not covered by the ID waiver.

Numbers of Individuals on CSB Mental Health Services Waiting Lists
Diagnostic Information: January – April 2011

Diagnosis	Adult	C & A	Diagnosis	Adult	C & A
Serious Mental Illness (SMI)	2,754		Co-occurring MI/ID	138	30
Serious Emotional Disturbance (SED)		1,109	Co-occurring MI/ID/SUD	20	0
At Risk for SED		149	Developmental Disability (Not ID)	23	18
Any Other MI Diagnosis	418	246	Not Known at This Time	396	227
Co-occurring MI/SUD	805	36			

Numbers of Individuals on CSB Developmental Services Waiting Lists
Diagnostic Information: January – April 2011

Diagnosis	Adult	C & A	Diagnosis	Adult	C & A
Intellectual Disability	3,428	1,710	Co-occurring ID/MI/SUD	16	1
Cognitive Developmental Delay	31	412	Autism	235	349
At Risk for Cognitive Developmental Delay		33	Developmental Disability (Not ID/or Autism)	47	114
Co-occurring ID/MI	592	189			
Co-occurring ID/SUD	8	5	Not Known at This Time	19	27

Numbers of Individuals on CSB Substance Abuse Services Waiting Lists
Diagnostic Information: January – April 2011

Diagnosis	Adult	Adol.	Diagnosis	Adult	Adol.
Substance Dependence	919	25	Co-occurring SUD/MR	6	0
Substance Abuse	314	28	Co-occurring SUD/MI/ID	9	0
Any Other SA Diagnosis	62	14	Developmental Disability (Not ID)	9	0
Co-occurring SUD/MI	688	45	Not Known at This Time	309	16

The following table depicts the length of time that individuals were reported to be on CSB mental health, developmental, or substance abuse services waiting lists.

Length of Time on CSB Waiting Lists for All Services: January – April 2011

	MH Services		DEV Services		SUD Services		Total
	Adult	C & A	Adult	C & A	Adult	Adol.	
Under 1 Month	138	54	16	8	62	1	279
1 to 3 Months	2,397	1,306	302	244	1,092	80	5,421
4 to 12 Months	839	269	455	377	426	20	2386
13 to 24 Months	325	38	511	445	112	0	1,431
25 to 36 Months	116	10	458	439	41	0	1,064
37 to 48 Months	54	8	405	317	12	0	796
49 to 60 Months	26	6	328	152	10	0	522
61 to 72 Months	18	3	319	112	3	0	455
73+ Months	93	3	1,192	281	12	0	1,581
Not Reported	11	2	54	0	2	0	69
Total	4,017	1,699	4,040	2,375	1,772	101	14,004

For individuals reported to be on CSB waiting lists for 73 or more months, the most frequently listed services for which the individuals were waiting follow.

- For adults on mental health services wait lists: psychiatric (47), medication management (45), and case management services (27);
- For adults and children and adolescents on developmental services wait lists:
  - Adults: supportive services (supportive living, in-home, personal assistance, companion services) (549), supervised residential (278), and intensive residential (congregate) services (259), and
  - Children and adolescents: supportive services (supportive living, in-home, personal assistance, companion services) (196), assistive technology (100), and environmental modifications (74); and
- For adults on substance abuse services wait lists: medication assisted treatment (9), case management services (8), and outpatient services (7).

Needed services and average service wait times by program area are depicted for adults (ages 18 and over) and children and adolescents (ages 17 and below) on the following tables.

Numbers of Individuals on CSB Mental Health Services Waiting Lists by Service: January – April 2011

Service	Adult	C &A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,181	575	Intensive In-Home	3	315
Medication Management	1,308	425	Assertive Community Treatment	196	6
Counseling and Psychotherapy	1,639	936			
Case Management					
Case Management	879	271			
Day Support Services					
Day Treatment/Partial Hospitalization	270	157	Rehabilitation	339	26
Employment Services					
Sheltered Employment	183	8	Group Supported Employment	87	7
Individual Supported Employment	491	12			
Residential Services					
Highly Intensive	130	15	Supervised	328	17
Intensive	180	24	Supportive	752	162

In June 2011, 155 individuals in state hospitals were identified as having their discharges delayed due to extraordinary barriers.

Numbers of Individuals on CSB Developmental Services Waiting Lists by Service: January – April 2011

Service	Adult	C & A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	270	167	Behavior Management	338	386
Medication Management	425	273			

Service	Adult	C & A	Service	Adult	C&A
Case Management					
Case Management	1,017	1,032			
Day Support Services					
Habilitation (Center Non-Center)	1,027	681			
Employment Services					
Sheltered Employment/Prevocational	613	135	Group Supported Employment	548	124
Individual Supported Employment	576	114			
Residential Services					
Highly Intensive (ICF/ID)	176	63	Supportive(Supported Living, In-Home, Personal Assistance, Companion Services, Respite)	2,003	1,665
Intensive (Congregate)	748	164			
Supervised (Congregate)	887	160			
Other Supports					
Nursing Services	121	167	Environmental Modifications	325	561
Assistive Technology	464	809	Personal Response System (PERS)	30	45
Therapeutic Consultation	270	335			

Numbers of Individuals on CSB Substance Abuse Services Waiting Lists by Service: January - April, 2011

Service	Adult	Adol.	Service	Adult	Adol.
Outpatient Services					
Intensive SA Outpatient	430	31	Medication Assisted Treatment	381	9
Outpatient	975	51			
Case Management					
Case Management	643	22			
Day Support Services					
Day Treatment	56	13	Rehabilitation	40	0
Partial Hospitalization	23	7			
Employment Services					
Sheltered Employment	34	0	Group Supported Employment	44	0
Individual Supported Employment	82	4			
Residential Services					
Highly Intensive	111	4	Supervised	89	1
Intensive	238	7	Supportive	91	3

A total of 288 individuals on waiting lists for CSB mental health, developmental, or substance abuse services are age 65 or older. Of these, 240 were currently receiving at least one CSB service. Of individuals age 65 and over who are on CSB waiting lists, 181 were waiting for mental health services, 106 were waiting for developmental services, and one was waiting for substance abuse services. In CSBs that provide targeted services for older adults, service wait times for those individuals may be significantly higher than those for the general adult population. For example, Arlington CSB, which tracks older adult services separately, reported that older adult, on average, waited 24 weeks for highly intensive residential services, 20 weeks

for counseling and psychotherapy and for supportive residential services, and waited eight weeks for psychiatric services and for medication services.

Average Wait Times in Weeks for CSB Behavioral Health and Developmental Services

As part of the waiting list survey, CSBs were asked to estimate the number of weeks individuals waited prior to their receipt of specific services. Average wait times for specific services follow.

	MH Services		DEV Services		SUD Services	
Service	**Adults**	**C & A**	**Adults**	**C & A**	**Adults**	**Adolescents**
Outpatient Services						
Medication Services	8.10	7.44	15.20	13.68	6.55	6.11
Psychiatric Services	8.21	7.17	13.93	12.58	6.54	6.26
Counseling & Psychotherapy	8.40	5.13			5.39	4.91
Behavior Management			45.80	1.33		
Intensive SA Outpatient					4.63	4.94
Intensive In-Home		2.79				
Medication Assisted Treatment					15.90	23.00
Assertive Community Treatment	2.30					
Case Management Services						
Case Management Services	9.99	3.77	19.33	15.06	6.63	4.40
Day Support Services						
Day Treatment/Partial Hospitalization	35.5	6.89			20.5	
Ambulatory Crisis Stabilization Services	2.06	0.43				
Rehabilitation or Habilitation	32.79	3.33	57.11	41.75	4.09	2
Employment Services						
Sheltered Employment	3.33		54.11	10.50	1.00	0
Transitional or Supported Employment	4.33		61.27	14.50	2.00	0
Group Supported Employment	57.14	0	43.33	6.00	31.00	0
Residential Services						
Highly Intensive Residential Services	105.00		75.60	6	3.40	0
Intensive Residential Services	55.50		82.36	7	22.69	8
Supervised Residential Services	40.34	0	68.46	6	2.33	0
Supportive Residential Services	39.46	1.50	73.44	19.50	6.80	1
ID Waiver Services						
Nursing Services			32.30	11.63		
Environmental Modifications			36.08	15.64		
Assistive Technology			41.54	14.50		
Personal Response System (PERS)			74.33	27.25		
Therapeutic Consultation			46.11	11.00		

Limited Services	**Average Wait Time**
Motivational Treatment Services	2.97
Consumer Monitoring Services	1.13
Assessment and Evaluation Services	3.72
Early Intervention Services	2.44

Other Indicators of Community-Based Services Needs

In addition to individuals on waiting lists for CSB services, there are additional disability-specific, community-based service needs that are significant and compelling.

- Virginia Department of Education December 1, 2010 counts identified 9,562 students ages six to 22+ with a primary disability (as defined by special education law) of emotional disturbance and 9,784 students with intellectual disability who are receiving special education services. Counts for children age three to five identified 8,244 children with a developmental disability and 935 children with an autism spectrum disorder. The total number of students identified with an autism spectrum disorder was 11,703.
- In January 2010, Virginia communities participated in a statewide one-day point-in-time count and found 8,883 homeless persons. Of these, 1,479 individuals (17 percent of all persons who were homeless) had been homeless for a year or longer or had been homeless at least three times in the previous four years and also had a disabling condition (i.e., meeting the HUD definition of chronic homelessness). As a one-day point-in-time survey, this significantly under reports the total number of individuals who are homeless.

Anticipated Changes Influencing Future Demand for Behavioral Health and Developmental Services

The Department anticipates a variety of factors will affect future demand for services provided by the public behavioral health and developmental services system. These include:

- Increasing services demand resulting from Virginia demographic trends, particularly the:
  - continued significant population growth in Northern, Central, and Eastern Virginia;
  - growing numbers of older adults who will require behavioral health services to enable them to reside in their homes or other community placements; and
  - increasing cultural and linguistic diversity of Virginia's population;
- Continuing growth in the number of individuals on the urgent and non-urgent waiting lists for Medicaid intellectual disability waiver services and supports;
- Increasing referrals to the services system and changing responsibilities for it resulting from Patient Protection and Affordable Care Act (PPACA) implementation, including changes to Virginia's Medical Assistance Program and the federal Mental Health and Substance Abuse Administration (SAMHSA) block grants;
- Growing demand for specialized interventions and care by individuals with co-occurring combinations of mental illnesses, substance use disorders, intellectual disability or other cognitive deficits, chronic medical conditions, or behavioral challenges;
- Growing numbers of individuals receiving behavioral health or developmental services who have complex medication regimes or serious medical conditions requiring specialized health services;
- Escalating pressures to provide services in a secure environment to individuals who are civilly committed to the Department as sexually violent predators;
- Emerging responsibilities to serve individuals with developmental disabilities, including autism spectrum disorders;
- Increasing numbers of veterans returning to Virginia from Iraq and Afghanistan who have behavioral health service needs;
- Increasing numbers of adults and juveniles in the criminal justice system with identified behavioral health service needs; and
- Additional demands for specialized services resulting from the aging of current caregivers.

V. SERVICES SYSTEM TRANSFORMATION – VISION, VALUES, AND STRATEGIC DIRECTIONS

Integrated Strategic Plan for Virginia's Services System

In 2006, the then Department of Mental Health, Mental Retardation and Substance Abuse Services adopted *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System* (ISP) to provide a strategic blueprint for transforming Virginia's publicly-funded services system. The ISP includes values, critical success factors, and implementation action steps that are essential building blocks for the realization of the vision of a "consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships" (State Board Policy 1036 (SYS) 05-3). The vision and strategic framework provided in the ISP respond to the U.S. Supreme Court Olmstead [Olmstead v. L.C., 119 S. Ct. 2176 (1999)] and continue to provide strategic direction for Virginia's behavioral health and developmental services system.

The ISP affirms that individuals with mental health or substance use disorders or intellectual disability are members of the community in which they live and should enjoy the same opportunities for quality of life. It includes the overarching goal to provide or assist individuals in obtaining services and supports based on informed choice that would enable them to:

- Attain their highest achievable level of health and wellness;
- Live as independently as possible, with children living with their families;
- Engage in meaningful activities, including school attendance or work in jobs that they have chosen; and
- Participate in community, social, recreational, and educational activities.

The ISP articulated the following services system values and principles.

- Services and supports are person-centered, with the specific needs of each individual at the center of service planning and care coordination. Regardless of where an individual lives in Virginia, there is access to a broad array of services and supports that promote independence and enable individuals to live in their own homes wherever possible. Services and supports are flexible, allow for the greatest amount of individual choice possible, and provide an array of acceptable options to meet a range of individual needs.
- A consistent minimum level of services and supports is available across the system, with timely access to needed services. Services and supports are available and delivered as close as possible to the individual's home community in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services. Services are universally and equally accessible regardless of the individual's payment source.
- The services system is designed to intervene early to minimize crises through early screening and assessment, appropriate interventions that keep individuals receiving services connected to their families and natural supports, and seamless access to services. Prevention, early intervention, and family support services are critical components of the services system. Crisis services are available 24 hours per day and seven days a week.
- Funding follows the individual to the extent possible and not a specific provider or service. Integrated funding reduces complexity and provides flexibility to create choices among services and supports that address an individual's unique needs.
- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.

- Services are of the highest possible quality and are based upon best and promising practices where they exist. Emphasis is placed on continuous quality improvement, workforce training and development, and use of technologies that promote efficiency and cost effectiveness at the provider and system levels.

The ISP described the public safety net and serves as the conceptual basis for State Board Policy 1038 (SYS) 05-5 The Safety Net of Public Services, which states that the Department and CSBs, as partners in the services system, are jointly responsible for assuring to the greatest extent practicable the provision of a safety net of appropriate public services and supports in safe and secure settings for individuals who:

- Are in crisis or have severe or complex conditions;
- Cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a highly structured or secure environment; and
- Are uninsured, under-insured, or otherwise economically unable to access appropriate service providers or alternatives.

Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia

The Department's Creating Opportunities Plan builds on the vision, values, and the critical success factors in the ISP and continues recent services system reform and transformation initiatives to advance a recovery and resilience-oriented and person-centered system of behavioral health and developmental services and supports. The purposes of the Creating Opportunities Plan are to:

- Achieve a *"Commonwealth of Opportunity"* for all Virginians, including individuals receiving behavioral health or developmental services;
- Continue progress in advancing the vision of self-determination, empowerment, recovery, resilience, health, and participation by individuals receiving services in all aspects of community life;
- Promote efficient and effective management of services system core functions and responsiveness to the needs of individuals receiving services and their families; and
- Communicate the Department's strategic agenda and priority initiatives to the key decision-makers in state government, individuals receiving services and their families, public and private providers, advocates, and other interested stakeholders.

Creating Opportunities Plan strategic focus areas follow:

Behavioral Health Services

1. Emergency response system for individuals in crisis;
2. Peer and recovery support services;
3. Substance abuse treatment services;
4. State hospital effectiveness and efficiency; and
5. Child and adolescent behavioral health services.

Developmental Services

1. Community developmental services and supports capacity; and
2. Autism spectrum disorder and developmental disabilities services and supports.

Systemwide Supports and Services

1. Housing;
2. Employment opportunities; and
3. Case management system capability.

In addition, the Creating Opportunities Plan included several major Department activities, including participating in the work of the Secretary of Health and Human Resources' Office of Health Care Reform; addressing sexually violent predator service capacity issues; and implementing a state facility electronic health record system and health information exchange technology.

The plan was presented to and endorsed by the State Board of Behavioral Health and Developmental Services on June 25, 2010. Upon the completion of the Creating Opportunities Plan, the Department established strategic initiative implementation teams to define initiative outcomes and products with specific action steps for successful implementation. Several initiatives used parallel planning processes and did not require an implementation team for stakeholder input.

The Creating Opportunities planning process involved broad stakeholder participation on initial behavioral health and developmental planning teams that worked with the Department to identify strategic priorities for the Creating Opportunities Plan or on implementation action teams for specific strategic initiatives or both. These teams were co-led by Department staff and community stakeholders and included individuals receiving services, family members, advocacy organizations, and representatives of public and private services providers, provider associations, universities, and state and local agencies.

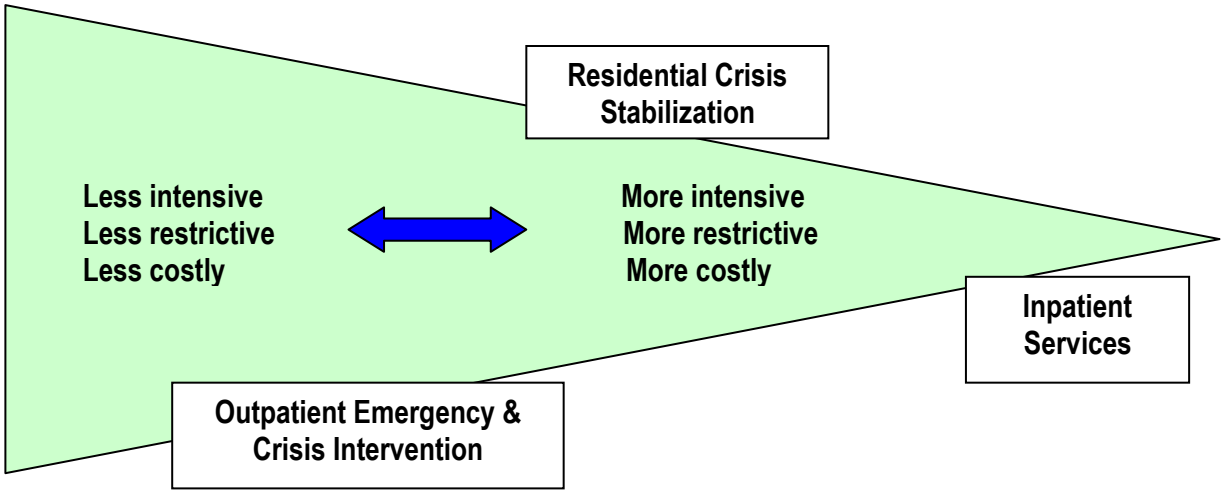
VI. BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES SYSTEM STRATEGIC INITIATIVES

Behavioral Health Services Strategic Initiatives

A. *EMERGENCY RESPONSE AND CRISIS PREVENTION AND DIVERSION SERVICES*

Emergency and Crisis Response Services

The emergency response and crisis intervention system is an array of many different types of services. Toward one end of the array are outpatient and ambulatory services. These services are less intensive, less restrictive, and less costly. At the other end of the array are more intensive, more restrictive and more costly services such as residential crisis stabilization and inpatient services. These more intensive services offer a greater degree of clinical supervision and security, which can be important considerations when an individual's safety is concerned.



The ***most restrictive services*** include state hospital beds for voluntary, temporary detention order (TDO), and commitment admissions; local hospital psychiatric beds for voluntary, TDO, and commitment admissions; and residential crisis stabilization units. ***Mid-range services*** include ambulatory (23-hou) crisis stabilization; mobile crisis stabilization; crisis intervention teams (CIT) or similar programs, psychiatric evaluation and medication administration (within 24 hours); psychiatric crisis consultation; face-to-face crisis intervention (immediate); and face-to-face crisis appointment (next work day). The ***least restrictive services*** include telephone crisis counseling (extended); telephone crisis contact (brief); and warm lines. Additionally, emergency services include pre-hearing assessment, and commitment hearing attendance.

The Office of the Inspector General (OIG) *Study of CSB Emergency Services (*2005) found:

> *"The majority of Virginia's CSBs do not provide a comprehensive range of crisis intervention services for those with mental illness and substance use disorders. Almost all CSBs offer the least restrictive Crisis Response, Resolution and Referral Services and most restrictive Inpatient Hospital Services, but very few offer the critical mid-range Community Crisis Stabilization Programs that effectively stabilize difficult crisis situations in the community."*

This report provided an important foundation for subsequent capacity-building and quality improvement in the CSB emergency response system. In 2006, the Mental Health Law Reform Commission was established by the Virginia Supreme Court Chief Justice to study

Virginia's mental health statutes and behavioral health services system. Less than a year after the Commission study began, the deadliest mass shooting on a U.S. university campus occurred on April 16, 2007 at Virginia Polytechnic Institute and State University (Virginia Tech) in Blacksburg. In its report, the Virginia Tech Review Panel, appointed by then Governor Kaine to conduct an independent investigation of the shooting, highlighted many weaknesses in the involuntary treatment process and inadequacies in mental health services, particularly short-term crisis stabilization and comprehensive outpatient services.

The 2008 General Assembly enacted a package of reforms to Virginia's involuntary treatment laws that were informed by the Mental Health Law Commission and the Virginia Tech Review Panel. Additional reforms were enacted in 2009 to make the involuntary process more focused on individual needs and establish a comprehensive mandatory outpatient treatment procedure for minors. Accompanying these statutory reforms was a 2008-2010 initiative to expand crisis stabilization and other "safety net" services.

However, even with this initial investment, Virginia continues to lack a consistent basic array of emergency and crisis response services statewide and persons with mental health or substance use disorders continue to be involuntarily hospitalized or incarcerated in large numbers. The Department and Creating Opportunities Emergency Response Team surveyed CSBs and local hospitals in March-April 2011 to update the 2005 emergency response baseline and identify priorities for bringing CSBs to a baseline of services. Survey results of particular note were the general unavailability of psychiatric evaluation and medication administration within 24 hours and psychiatric crisis consultation and the need for additional inpatient, residential crisis stabilization, and detox service capacity to improve timely access. CSBs reported that about half of all crisis contacts (interventions) are persons who are not known to or admitted CSB services and stressed the importance of immediate access and education regarding community resources and outreach. The survey findings indicate that a safety net of basic services is indeed widely available in Virginia, but just barely so, and that behavioral health providers and other emergency service partners are severely challenged every day to access services for the people they serve. In other words, Virginia's "safety net" of available services is in place, but it is extremely thin.

The work of the Emergency Response Team included a survey conducted by the Virginia Hospital and Healthcare Association in March 2011 of community inpatient psychiatric units and emergency departments to obtain their perspectives on Virginia's emergency services system. Thirty-one hospitals with psychiatric units responded to the survey. Of those, 20 hospitals, which account for about two-thirds of all inpatient psychiatric beds, responded. Of hospitals without psychiatric units, 12 emergency departments provided responses to the survey questions Survey responses follow:

CSB Emergency Services:	Psychiatric Units	Emergency Departments
Function well most of the time	48%	42%
Function well for all but the most challenging individuals	39%	33%
Do not function well most of the time	13%	25%

Respondents expressed needs for more CSB emergency services staff, better access to CSB emergency services staff outside normal working hours, and more inpatient beds. They also noted that despite efforts to bring more consistency to emergency services practices across the state, survey results suggest that the desired degree of consistency has not been achieved.

The Emergency Response Team recommended that priority consideration be given to the future development of following crisis services: local acute inpatient hospitalization, detoxification and other substance abuse services, crisis intervention teams and similar

criminal justice behavioral health interventions, therapeutic drop-off centers for law enforcement, and psychiatric evaluations and medication administration within 24 hours. The team also recognized current demand on the services system for inpatient services but concluded that this demand could be reduced by expanding community-based crisis stabilization alternatives.

By the time persons with mental health or substance use disorders enter the behavioral health emergency services system, they have often experienced an accumulation of events and circumstances that have contributed to their presenting crisis. Even with the complex nature of psychiatric disorders, many crises could have been prevented if the right services and supports were accessible at the right time. Non-crisis "upstream" services and supports help people to manage their health and wellness, maintain their living situation, interact effectively with others in their lives, thrive in their community, and experience recovery. The Emergency Response team recommended that priority consideration be given to possible future capacity-building initiatives in the following non-crisis services areas: case management, especially intensive case management or Critical Time Intervention; mental health supports; psychiatric services and medication management; PACT (Program of Assertive Community Treatment) teams; peer support; and wrap-around services that accompany intensive case management and emergency critical time intervention.

Suicide prevention initiatives also are critically important. According to the Virginia Department of Health (VDH), there were 4,344 suicide deaths in Virginia between 2004 and 2008, for a 5-year suicide rate of 11.4 per 100,000 population. Suicide was the 7th leading cause of death for Virginians 10 years of age and older and the rate of suicide deaths increased by almost 12 percent from 2004-2008. The Department continues to provide leadership with the VDH in cross-agency activities to promote awareness throughout Virginia aimed at reducing the incidence of suicide. Following the completion of *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia* (SD 17, 2004), the Department was designated by the General Assembly as Virginia's lead agency for suicide prevention across the life span. Implementation of this plan has been hampered by the lack of dedicated resources in the Department.

The following populations were identified by the Creating Opportunities Emergency Response Team as having particular issues accessing emergency services.

- ***Individuals with Brain Injuries*** - In two separate studies in 2007, the Joint Legislative and Audit Review Commission (JLARC) described the lack of access to services for persons with brain injury who are experiencing behavioral and psychiatric issues. This lack of access to appropriate treatment can allow behavior problems to escalate, resulting in the individual being arrested and incarcerated.
- ***Military Veterans and Families*** - Virginia continues to develop its services and supports for veterans with stress-related and traumatic brain injuries. The Virginia Wounded Warriors Program (VWWP) offers services and supports to veterans and their families through a network of community-based services, including emergency and crisis response services, coordinated through regional VWWP consortia made up of community providers, including CSBs, brain injury services providers, VA Medical facilities and other public and private providers.
- ***Individuals with Intellectual Disability*** - In the 2005 emergency services study, the OIG found a lack of access in most CSBs to appropriate emergency response and crisis intervention for persons with intellectual disability. Because state hospital and training center roles were not clear, persons with intellectual disability were referred to services that were not appropriate. The Department and CSBs will begin to address this underserved group more directly with the FY 2012 appropriation of $ 5 million to establish community crisis intervention services in each region for individuals with intellectual disability and co-occurring mental health disorders.

- ***Older Adults*** – The demand for crisis intervention for older adults is rising as the proportion of older adults in the population increases. Specialized crisis response services for older individuals with behavioral health disorders are not widely or routinely available. The Department continues to work closely with health and long-term care partners to strengthen the availability of services and supports for these individuals, including emergency and crisis response services.
- ***Children and Youth*** –An extensive survey of CSBs conducted as part of the Creating Opportunities Children's Mental Health Services strategic initiative found that the crisis response service category had the most significant gaps and was the category in which the largest number of CSBs did not provide services at all.

As these populations continue to grow, Virginia will experience increased demand for access to emergency and crisis response services, as well as ongoing services and supports that help to prevent these individuals from experiencing crises.

Recovery-Focused Emergency and Crisis Response

Peer-to-peer support throughout the full continuum of emergency and crisis response services can be enormously positive for persons in psychiatric crisis because this person-centered approach has been proven to reduce the trauma impact of crisis intervention. Access to a person who has "walked this path" – a peer – is especially important in reducing fear, fostering hope, and restoring the person's sense of control in the midst of the crisis. Possible roles for peers in delivering emergency and crisis services follow.

- ***Early Crisis Intervention*** – Assigned peer partners can assist individuals who are still functioning in their community but are beginning to show signs of psychiatric distress by linking the individual with other peers and providing recovery information. Peers also can sponsor support groups and staff peer resource centers.
- ***Preadmission Screening/Crisis Intervention*** - Peers can assist in this process by providing a peer point of view, being assuring during waiting periods, providing information on the crisis process, assisting individuals to voice their wishes, and providing wellness checks and follow up after the crisis has been stabilized.
- ***Crisis Stabilization*** - Peers can inform and link the individual in crisis to peer resources in the community, lead groups, educate on Wellness Recovery Action Plans (WRAP), talk about recovery, provide hope, and share their personal stories. If the individual has been hospitalized, a peer can help the individual find his or her voice by helping to articulate what the individual needs and how he or she feels.
- ***Diversion*** – Peers can serve as mentors, comforters, coaches, and active listeners in homes, shelters, recovery sites, and other places in the community to divert individuals from hospitalization.
- ***Respite*** – Peers can offer to the person a sense of security and trust and help provide a measure of relief to the family and the individual and positive distraction from the impact of the individual's illness.
- ***Wrap-Around*** **Supports** – Peers can help link the individual to peer-to-peer post-crisis supports, which can provide an opportunity for peers to share their knowledge of recovery resources, wellness techniques, and other useful knowledge and information.

Peers and peer supports are not widely used by CSBs in the emergency services and crisis intervention context. The 2011 CSB emergency services survey found that just under one-third (32 percent) of the CSBs provide access to peers to persons in crisis. Many of these CSBs reported the positive benefits of doing so but noted that access is limited, for example, to certain circumstances or certain program locations. CSBs that do not provide access to peers in crisis reported a number of impediments to using peers, most commonly, limited

availability of peers even if peer support is provided in other services and lack of funding and staff resources.

Despite the considerable focus on, investment in, and training about emergency and crisis services since 2005, the experiences of persons in crises continue to vary considerably statewide. In addition to inconsistencies in the array of available and accessible services, providers and partners do not always deliver services that represent "best practice" in the field. Two consensus best practices endorsed by the Creating Opportunities Emergency Response team are the 2009 federal Substance Abuse and Mental Health Services Administration (SAMHSA) *Practice Guidelines: Core Elements for Response to Mental Health Crisis,* which provides a synopsis of service delivery values and principles of person-centered care, and the wide and routine use of advance planning, including psychiatric advance directives and WRAP planning. The team also recommended small practice changes to help reduce the traumatic effects of the crisis on individuals and make the crisis response more person-centered, humane, and positive by:

- Making educational literature about the TDO process available at the outset of a crisis event to both the individual in crisis and his or her family;
- Having informational literature that describes "what to do if you are having a mental health crisis" at all service locations;
- Posting crisis line telephone numbers widely in the community;
- Proactively disseminating information about how to access peer support services;
- Educating and linking families to the family support networks and resources;
- Making literature about various mental illnesses and related issues readily available; and
- Providing access to resources that help individuals develop advance directives, WRAP planning, and other recovery tools.

Diversion of Individuals in Crisis from the Criminal Justice System

Voluntary alternatives to hospital treatment and services to divert individuals from jail need to be improved. According to a June 2009 study published by the Council on State Governments Research Center, nearly 17 percent of all individuals booked into jails have a serious mental illness. When post-traumatic stress disorder is added to the calculation, the average rises to 19 percent (Steadman, et. al. 2009).

The Department partners with public safety agencies to implement the Sequential Intercept Model; develop the competence of localities through Cross Systems Mapping to identify the most effective points of intersection and appropriate interventions that prevent or reduce an individual's involvement in the criminal justice system and promote access community services and supports; and enhance and expand jail diversion and criminal justice-behavioral health collaborative programs across Virginia.

Goal, Objectives, and Implementation Action Steps

Goal: Strengthen the responsiveness of the emergency response system and maximize the consistency, availability, and accessibility of services for individuals in crisis across Virginia.

Objectives and Implementation Action Steps

1. Enhance statewide emergency response and crisis prevention and diversion services capacity.

a. Increase access to an adequate and more consistent continuum of emergency and crisis response services, including crisis stabilization and local reception or drop-off centers.

b. Increase access to non-crisis services or supports determined to be the most effective in preventing individuals from experiencing crises or diverting individuals in crisis from hospital-based inpatient psychiatric treatment.

c. Facilitate the consistent operation of crisis intervention services through ongoing activities of the Department's crisis intervention specialist.

d. Continue to plan and implement cross-agency suicide prevention initiatives across the Commonwealth.

2. Increase the quantity and quality of peer support in the crisis continuum.

a. Recruit and support additional trained peer support providers and use these staff in the delivery of emergency and crisis services by:
   - Generating interest among peers and services providers through active networking with statewide mental health and substance abuse organizations, peer-run service providers and organizations, peer advisory councils, and on-line peer support recovery websites;
   - Establishing peer support as a separate discipline with defined competencies and training requirements and a distinct service; and
   - Providing ongoing education and support to crisis response systems on how to use peer support workers and access peer networks statewide.

b. Implement SAMHSA Practice *Guidelines: Core Elements for Response to Mental Health Crisis* systemwide by:
   - Developing a web-based recovery training module for emergency services;
   - Conducting educational events systemwide on best practices in crisis stabilization, including the use of the practice guidelines; and
   - Providing provider oversight and mentoring to support use of the guidelines.

c. Increase utilization of recovery resources by providers of crisis services by:
   - Compiling and disseminating materials for individuals and families in crisis; and
   - Increasing the use of wellness recovery action plans and advance directives by individuals receiving services and staff in routine service delivery.

3. Enhance the Commonwealth's capacity to safely and effectively intervene to prevent or reduce the involvement of individuals with mental health and substance use disorders in the criminal justice system.

a. Continue to support and enhance collaboration, education, and criminal justice-behavioral health partnerships at the state, regional, and local levels.

b. Conduct Cross-Systems Mapping workshops that enable communities to review local resources, identify gaps, and develop action plans to improve criminal justice and behavioral health systems interoperability.

c. Support local law enforcement interventions to prevent individuals who are in crisis from involvement in the criminal justice system by providing Crisis Intervention Team (CIT) training, promoting CIT program development and outcomes measurement, and establishing police reception and drop-off centers.

d. Expand the array and capacity of jail diversion services, including pre-and post-booking, pre-trial alternatives, and community treatment services that prevent or divert individuals from incarceration.

e. Encourage CSB participation on local drug court planning and implementation committees.

f. Provide training to court personnel (judiciary, prosecutors, defense bar and other attorneys, clerks and bailiffs), probation and parole, community corrections, jail and other corrections staff, and emergency services workers on:
   - Basic mental illness,

- Access to services,
- Basic de-escalation,
- Civil commitment procedures and impact on individuals,
- Competency restoration, and
- Insanity defense procedures and their impact.

g. Explore opportunities for peers with a lived criminal justice experience to support individuals with mental illness who are involved with the criminal justice system.

B. Peer Services and Peer Provided Recovery Supports

Peer support is recognized as an important factor in the recovery process for many individuals with mental health, substance use, or co-occurring disorders. The 2010 Recovery Oriented System Indicator (ROSI) survey of 3,559 adult CSB mental health service recipients reported that 54 percent of respondents scored their system's recovery orientation above average and 46 percent below average. Respondents said what made the most difference to them was the availability of peer advocates to turn to when they were needed but only 47 percent reported that they have a peer advocate to turn to when they needed one.

At the federal level, SAMHSA has identified Recovery Support as a priority strategic initiative in *"Leading Change: A Plan for SAMHSA's Role and Actions 2011-2014."* A primary goal within that initiative promotes peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community. SAMHSA's goals will be translated into expectations for states receiving mental health and substance abuse block grants. The federal Centers for Medicare and Medicaid Services (CMS) also has approved the use of Medicaid funding for Peer Recovery Supports services. CMS stated in a letter to state Medicaid offices in August 2007 that it "recognizes that the experiences of peer support providers, as consumers of mental health and substance abuse services, can be an important component in a State's delivery of effective treatment."

Federal, state, and local funding in Virginia supports direct services provided to individuals by individuals who have themselves experienced mental health, substance use, or co-occurring disorders, i.e., by peers. Peer-provided and peer-run services and supports are delivered through CSBs, state hospitals, and peer-operated programs. This includes CSBs and state hospitals hiring their own peer staff and providing support for independent programs managed by peers through contracts or other partnership arrangements. These activities sustain the important ongoing partnership between the peer community and traditional treatment providers. They create empowering experiences for peers and are intended to reduce stigma and foster a more welcoming and responsive system of care. The Department currently contracts with the following peer-run service organizations.

Organization	Description
Center for Recovery and Wellness	This program provides recovery oriented training, socialization, and peer support services in Lynchburg and surrounding counties.
Depression and Bi-Polar Support Alliance	This program provides support groups using the Pathways to Recovery Program model and an annual retreat to participants in Northern Virginia.
Friends4 Recovery Whole Health Center	This bi-lingual English and Spanish program provides peer support services and wellness training in the Richmond area.
Laurie Mitchell Employment Center	This program offers peer-provided employment training and supports, computer classes, resume writing, interview training, and social activities to participants in Northern Virginia.

Organization	Description
Middle Peninsula/Northern Neck Consumer Operated Program	This program provides peer support and wellness programs in the Middle Peninsula/Northern Neck service area.
On Our Own of Roanoke Valley	This program provides peer support services, veteran's outreach, Wellness Recovery Plan (WRAP) facilitation, and wellness groups.
On Our Own of Charlottesville	This program provides co-occurring support, psycho-social programs, WRAP facilitation, wellness groups, and peer-provided outreach to homeless persons.
PD 19/House of Job/Voices Against Crack	This program uses recovery coaches and is working in Petersburg and surrounding communities to establish recovery housing.
Region Ten CSB	This program uses recovery coaches and is working with individuals receiving services in the Charlottesville area to develop Recovery Action Plans. (RAP)
SpiritWorks	This program provides local peer support services in Williamsburg and surrounding communities, works with individuals receiving services to develop RAPs, and provides technical assistance to peer-run programs.
The Coalfields Coalition	The coalition provides peer support services, using RAP, and works closely with the regional substance abuse services coalition in Southwest Virginia. (Cumberland Mountain, PD 1 and Dickenson County CSBs).
WeCare, Inc	This program provides peer support services to individuals with a serious mental illness and substance abuse issues in the Martinsville area.

Peer support services in Virginia can be expanded by changing the state Medicaid plan to add peer support as a distinct service. Providers of this new peer support service would need to demonstrate that they meet competency requirements through a state certification program for peer support specialists.

The Department contracts with the Mental Health America of Virginia (MHAV), National Alliance on Mental Illness (NAMI) Virginia, Substance Abuse Addiction and Recovery Alliance (SAARA), and Virginia Organization of Consumers Asserting Leadership (VOCAL) to provide support and training to individuals receiving services and family education about mental health or substance use disorders and their treatment. MHAV provides *Consumer Empowerment Leadership Training* (CELT) and *Wellness Advocacy and Leadership Through Technology* (WALTT). NAMI Virginia's individual and family education programs include *In Our Own Voice*, *Peer to Peer*, *Family to Family*, and *The Basics*. VOCAL provides technical assistance to peer-run programs, trains WRAP facilitators, and supports a statewide peer network and an annual conference for individuals receiving services.

The Creating Opportunities Peer Services and Recovery Supports Team recognized the systemwide need to further the Commonwealth's commitment to fulfilling promises to establish a consumer-focused behavioral health care delivery system. The team recommended that the Department establish an Office of Peer Services and Recovery Supports in the central office to develop and expand systemic and service level understanding of and capacity for peer-to-peer services and recovery supports. This new office would operate on the same recovery principles it would be espousing, including hope, empowerment, choice and inclusion, education, coaching, and mentoring. It would promote collaboration with and provide information and assistance to the peer community across the state in peer run and recovery-based programs, CSBs, and state facilities. The office also would assist and promote the inclusion of individuals and families with lived experiences in the work of Department and its community partners and would promote the benefits of peer services in the development of policies, communications, technical assistance, data collection, contracts, workforce development, and funding.

The Creating Opportunities Peer Services and Recovery Supports Team also recommended that an Advisory Committee be established by the Commissioner with a balanced representation from mental health and substance peer run and peer provided programs, advocacy groups, and stakeholders who have received services in the public and private system. This committee would work with central office staff to establish the Office of Peer Services and Recovery Supports and then serve in an advisory role to the office.

Goal, Objectives, and Implementation Action Steps

Goal: Increase use of peers in direct service roles and expand recovery support services across the Commonwealth.

Objectives and Implementation Action Steps

1. ***Increase opportunities for individual and family involvement in planning, evaluating, and delivering behavioral health and developmental services.***
   a. Continue to fund and support Virginia's statewide network of peer organizations and family alliances.
   b. Continue to fund a statewide recovery and peer-to-peer education program run by and for individuals receiving services and supports.
   c. Promote and expand training to prepare individuals receiving services and family members for meaningful roles in planning and policy making activities.
   d. Support CSB and state facility peer and family education and training.
   e. Keep peer-run programs, family organizations, and advocacy organizations fully informed about opportunities to be involved in system initiatives and activities.
2. ***Increase the quantity and quality of peer support services providers.***
   a. Continue to fund and support development and expansion of a wide range of peer services and peer provided recovery supports delivered through CSBs, state hospitals, and peer-operated programs.
   b. Provide ongoing education and support to public and private behavioral health providers aimed at increasing their use of peer support specialists and promoting effective collaborations with independent peer programs.
   c. Work with DMAS to establish Peer Support Services as a Covered State Medical Assistance Plan rehabilitation service and to adopt regulations that include a peer support services definition, program and provider requirements, and adequate reimbursement rates.
   d. Establish a state certification program for peer support specialists by:
      - Defining peer support services specialist responsibilities and core competencies;
      - Establishing experience, training, and testing requirements;
      - Developing curriculum components and training requirements;
      - Examining other states' peer services specialist certification approaches;
      - Determining the best certification mechanism and process for Virginia; and
      - Projecting peer support specialist certification implementation requirements.
   e. Implement a peer support specialist certification program contingent on resource availability.
3. ***Establish an Office of Peer Services and Recovery Supports in the Department's central office.***
   a. Establish a peer Advisory Council to assist Department leadership create the Office and provide ongoing interface with the peer community.
   b. Begin Office of Peer Services and Recovery Supports Office operations contingent on resource availability.

C. SUBSTANCE ABUSE SERVICES

Substance Abuse Treatment Services

Untreated substance use disorders costs Virginia millions of dollars in cost-shifting to the criminal justice system, the health care system, and lost productivity, not to mention the human suffering and effects on family and friends. A 2008 JLARC study, *Mitigating the Cost of Substance Abuse in Virginia,* conservatively estimated the cost in 2006 dollars to be $613 million to the criminal justice system alone. Of the 713 drug caused deaths reported by the Virginia Department of Health Office of the Chief Medical Examiner in 2009, 433 were due to prescription drugs, and 325 of these prescription drug deaths involved narcotic pain medication. This reflects a trend that began several years ago. The 2008 National Survey of Drug Use and Health, conducted annually by SAMHSA, estimates that 23.66 percent of Virginians over 12 engaged in binge drinking (5 or more drinks in one occasion), and 590,000 individuals met clinical requirements for abuse or dependence of either alcohol or illicit drugs.

Virginia has a low ranking among the states in support for community drug and alcohol treatment. A 2009 study by the National Center on Addiction and Substance Abuse at Columbia University (CASA) of 47 states and territories ranked Virginia 36th in per capita spending on substance abuse prevention, treatment and research ($5.65 per capita), behind other southeastern states such as Georgia, Louisiana, Mississippi, and Kentucky. The 2008 JLARC study determined that substance abuse treatment services provided by CSBs are effective and have the impact of lowering other costs to the Commonwealth; however, services are not widely accessible, especially to the majority of offenders returning to the community.

Substance misuse and addiction commonly lead to crimes and criminalization of addiction – 70 percent of Virginias' incarcerated populations have substance abuse issues that, if not addressed, considerably increase the risk of recidivism. Governor McDonnell's Virginia Prisoner and Juvenile Re-entry Council has recommended adoption of evidence-based treatment models at prisons and jails, and in the community, with improved coordination and continuity for the 13,000 inmates who return to Virginia communities each year.

Co-occurring substance use and mental health disorders are characterized by the simultaneous presence of two independent medical disorders – psychiatric disorders and alcohol or other drug use disorders - that can occur at any age. Co-occurring mental health and substance use disorders are common: 35 percent of people with serious mental illness use alcohol or other drugs in a way that compromises stable recovery, and 19 percent of persons with alcohol abuse or dependence meet criteria for a mental illness. The Department has adopted the *Comprehensive, Continuous, and Integrated System of Care (CCISC)* model at all levels of the services system. CCISC incorporates the principles of integrated system planning, a welcoming environment, uniform dual diagnosis program capability, universal practice guidelines, dual competence, concurrent treatment, and continuity of relationships with clinicians. (Minkoff, 1989, 1991, 2000, 2001)

Substance Abuse Prevention Priorities

Prevention is aimed at substantially reducing the incidence of alcohol, tobacco, and other drug use and abuse with a focus on enhancing protective factors and reducing risk factors. Protective factors, such as social and resistance skills, good family and school bonds, and the capacity to succeed in school and in social activities, can reduce the impact of risk factors. Risk factors may be biological, psychological, social, or environmental and can be present in individuals, families, schools, and the community. For example, when a child experiences a higher number of risk factors, such as poor school achievement, parents with poor family management skills, and neighborhoods where drug use is tolerated, the child is more likely to experiment and use alcohol, tobacco, or other drugs.

The Department oversees and supports substance abuse prevention services delivered through CSBs that are funded with Substance Abuse Prevention and Treatment Block Grant (SAPT) funds and comply with applicable federal regulations. The Department also supports a community-based prevention planning process involving human service providers, schools, law enforcement organizations, faith and business communities, and parents and youth who participate in prevention planning coalitions. In a survey conducted for the 2012-2018 Comprehensive State Plan, CSBs reported that prevention coalitions identified middle and elementary school students as priority populations targeted for focused prevention efforts. Availability of tobacco, alcohol, drugs, and other substances; family management problems; friends who engage in the problem behavior; and family history of problem behavior were identified as the most significant risk factors.

At the state level, the Department participates with 12 other state agencies on the Governor's Office of Substance Abuse Prevention Collaborative (GOSAP) to plan and direct statewide prevention initiatives. GOSAP members and others serve on the Advisory Committee for a five year Strategic Prevention Framework State Prevention Grant that is addressing the issue of motor vehicle crashes involving alcohol impaired drivers ages 15-24.

An amendment to the federal Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act requires that states conduct annual inspections of randomly selected tobacco retail outlets to determine the likelihood that underage youth can purchase tobacco products. As a condition for receipt of federal SAPT funds, which support community substance abuse treatment and prevention services, the state's noncompliance rate must not exceed a previously agreed upon target . Virginia's 11.3 percent noncompliance rate for the federal fiscal year 2010 is below the required 20 percent noncompliance target.

Goal, Objectives, and Implementation Action Steps

Goal: Increase the statewide availability of substance abuse services.

Objectives and Implementation Action Steps

1. ***Enhance access to a consistent array of substance abuse treatment services across Virginia.***
    a. Increase access to an adequate and more consistent array of substance abuse services, including case management, intensive outpatient services, medication assisted treatment, detoxification beds, and residential treatment for pregnant women and women with dependent children.
    b. Enhance uniform screening and assessment of co-occurring mental health and substance use disorders.
    c. Develop capacity to serve adolescents with substance use and co-occurring mental health disorders.
    d. Expand substance abuse peer recovery programs that provide group support, housing and employment assistance, day activity, and links to community resources.
    e. Provide structured, safe, sober living environments for adults who are actively engaged in treatment as a step down from detoxification or residential services.
    f. Expand Project Link, which provides intensive, coordinated interagency care for pregnant and post-partum women who are using drugs.
    g. Implement a structured system quality improvement practice model, such as the Network to Improve Addiction Treatment (NIATx).
    h. Assess and enhance the capability of CSBs to provide integrated assessment and treatment for individuals with co-occurring substance use and mental health disorders.

2. ***Foster interagency partnerships to provide services to individuals with substance use disorders.***
    a. Expand access to identification and intervention for offenders with substance use disorders in community correctional settings.
    b. Support DOC reestablishment of transitional therapeutic communities.
    c. Expand DRS substance abuse employment counselors in CSBs.
    d. Create a multi-agency work force development capacity focusing on the treatment of substance use disorders.
    e. Support DOC efforts to pilot the use of Oxford Houses for offender re-entry housing.
    f. Support the establishment and implementation of drug courts across Virginia.
3. ***Reduce the incidence of alcohol, tobacco, and other drug use and abuse among Virginia youth and adults.***
    a. Build and sustain collaborative relationships at the state level and support community-based prevention planning coalitions at the local level to implement strategies that reduce exposure to risk and enhance protective factors.
    b. Share training, technical assistance, and planning resources with a variety of agencies and organizations invested in reducing substance abuse and dependence.
    c. Continue to educate youth about the harmful effects of tobacco use and support tobacco specific prevention strategies and activities.

D. STATE HOSPITAL EFFECTIVENESS AND EFFICIENCY

State Facility Operations

The roles of state hospitals and private hospitals have continued to evolve as Virginia works to implement state policies promoting community-based care. Because their services are generally provided in very structured and secure treatment environments, state hospitals face the challenge of creating recovery-oriented, person-centered, and hopeful settings for treatment that aids the individual's return to his community, family, and life. Over the past five years, state hospitals have made significant progress in changing their cultures to support recovery, self-determination, empowerment, and person-centered planning.

Virginians from all parts of the state should be able to expect comparable levels of treatment effectiveness and efficiency from all state hospitals. Results of audits by national and state oversight, accrediting, and funding authorities have shown areas of excellence, along with inconsistencies, problems, and gaps in compliance among the hospitals. State hospitals now function with a high degree of independence from one another and from the central office. There are considerable differences in state hospital staffing patterns, organizational structures, and staff allocations. Hospital services, populations, policies, procedures, and practices also vary significantly. Some but not all of this variability may be appropriate to the functions performed and populations or regions served.

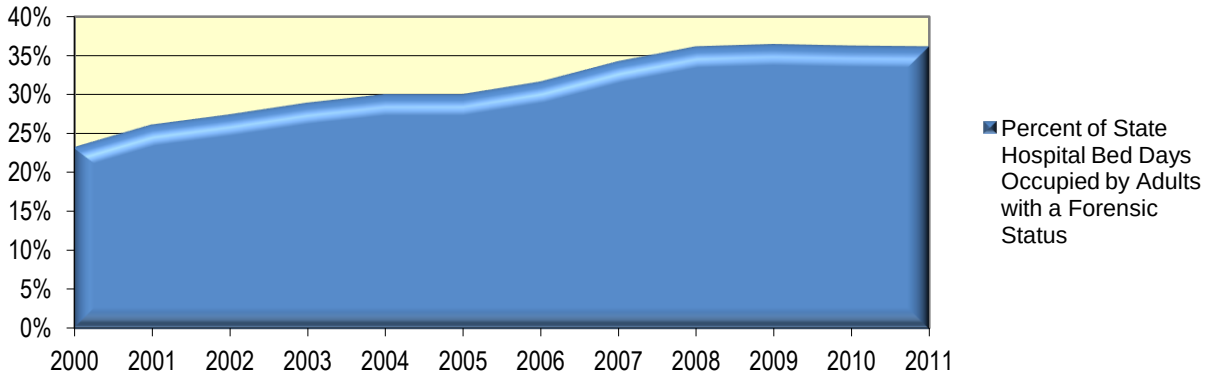
Access to and discharge of individuals from state hospitals and publically-funded care provided by private psychiatric hospitals is now managed by regional consortia of CSBs and other stakeholders in the jurisdictions served by the state hospitals. Active regional management is challenged by the continuing loss of private psychiatric beds and by regional differences in needs, resources, and service availability.

Demand Pressures on State Hospital Bed Capacity

The following facility populations are placing increasing demands on state facility bed use.

Forensic Services: State hospitals provide forensic evaluation, emergency and continuing treatment, and competency restoration services. In FY 2011, 1,198 unique adults with a

forensic legal status were served in state hospitals, occupying the equivalent of 474 beds. On average adults with a forensic status stayed 144 days compared to 82 days for a civil episode of care. This is due in part to the need to satisfy legal as well as clinical needs of these individuals. Between FY 2000 and FY 2011, total state hospital beds (forensic and civil) occupied by adults with a forensic status increased from 133,440 to 172,959 bed days or from 23 to 36 percent of state hospital bed days.



Adults with a forensic status receive services on state hospital civil units as well as at the maximum security and intermediate security units at Central State Hospital and minimum security units at Western and Eastern State Hospitals. In FY 2011, 23 percent of adult civil beds were occupied by adults with a forensic status, up from 20 percent in FY 2006.

Descriptions and specific issues in forensic services categories follow.

Category	Description/Issue
Persons Requiring Emergency Treatment Prior to or After Trial (§ 19.2-169.6)	A person with criminal charges or who is awaiting sentencing or serving a sentence in a local correctional facility may be admitted to an inpatient facility for emergency treatment upon a finding of probable cause that he or she has a mental illness and that there exists a substantial likelihood that he or she will, in the near future, cause serious physical harm to self or others as a result of that mental illness. These are typically acute treatment cases with brief lengths of stay but it is not uncommon for a person to be admitted under this status and for an order for forensic evaluation to then follow.
Evaluations of Competency to Stand Trial and Sanity at Time of Offense (§ 19.2-169.1 and 19.2-169.5)	Competency evaluations may be ordered for persons believed not to be competent. These evaluations allow a maximum 30-day inpatient stay. Although the Code expresses a preference that these evaluations be conducted on an outpatient basis whenever possible, some regions experience a shortage of qualified or willing evaluators. Additionally, the quality of outpatient evaluations (which are most often completed by persons in private practice who are not subject to any oversight or supervision) is uneven and may not meet professional practice standards. This can result in unnecessary admissions for restoration and in NGRI findings in cases where legal criteria do not appear to have been met.
Restoration of Competence to Stand Trial (§ 19.2-169.2)	After undergoing an initial evaluation of competence to stand trial, some defendants are adjudicated incompetent and ordered to undergo treatment to restore competence. These renewable orders are for up to six months of treatment (except for a small handful of misdemeanor charges, which can limit restoration to 45 days). Although the Code expresses a preference for outpatient competence restoration whenever possible, there is no reimbursement mechanism to CSBs for providing this service. Because outpatient service availability is limited, many courts are accustomed to ordering inpatient restoration, even in cases where the defendant could be expected to respond positively to outpatient (often jail-based) services.

Category	Description/Issue
Mandatory Parolees (§37.2-814 et seq)	These individuals are admitted directly to the Central State Hospital maximum security unit from the Department of Corrections as civilly committed persons upon the expiration of their sentences. They can then be transferred to civil units after an initial period of assessment. The large majority of these individuals do not appear to require maximum security, and often they have received services in state hospital civil units that are very familiar with them.
Not Guilty by Reason of Insanity (NGRI) Acquittees (§ 19.2-182.2 and 19.2-182.3)	These individuals are admitted first for an evaluation period of 45 days, after which about 20 percent are granted conditional release. Most are committed to the custody of the Commissioner, a renewable commitment that lasts for one year (misdemeanant acquittees are limited to one year of commitment as an NGRI acquittee, but can then be civilly committed if necessary). After commitment, NGRI acquittees can gradually obtain privileges that integrate increasing levels of community access until they are considered appropriate for conditional release. Acquittees remain under the jurisdiction of the original trial court, which makes the decision regarding conditional release and supervises the acquittee while on release. The average length of inpatient stay for NGRI acquittees is 6.3 years. By conservative estimate, there were about 10 persons in the last three years found NGRI who did not appear to meet legal criteria. Using forensic and average civil unit per diem costs and average lengths of stay, these individuals cost the Department just over $11.4 million.

Many persons referred to state hospitals for pretrial evaluation and treatment do not require the level of care provided in state hospitals and could be served on an outpatient basis. An organized, funded outpatient juvenile restoration system exists, but there is no funding available for outpatient adult restoration despite the fact that the need for adult restoration is far greater, and inpatient adult restoration is a very significant cost to the Department. Without developing community-focused forensic services, including outpatient and jail-based evaluations, restoration of competency, and treatment for persons found NGRI, the proportion of state hospital beds available for civil admissions will continue to decline.

Geriatric Services: Virginia serves many older adults with psychiatric needs in its state hospital geriatric centers (representing 12 percent of total hospital bed days in FY 2011) rather than in the community. This rate is exceeded by only four other states, in large part because the Commonwealth lacks adequate community alternatives that provide specialized programs and providers trained to address the specific needs of older individuals with mental health or substance use disorders.

Although some older adults living in nursing facilities are receiving case management and other specialized services through OBRA-87 funding, long-term care facilities that lack access to psychiatric care have difficulty managing behavioral challenges of residents with behavioral health disorders. This inability to manage behavior problems can translate into injuries to the individual or other residents and to caregivers. At times, long term care facilities respond to behavior problems with an over reliance on medications or by transferring those individuals to community hospitals or to state hospital geriatric centers.

State hospital geriatric centers are working with nursing facilities across Virginia to encourage and support the transition of individuals residing in the centers to the community. Using trial visits prior to discharge and teams of center clinical staff to provide telephone consultation, site visits, and other support to community caregivers following discharge of these individuals, some of them have been integrated into community settings.

To address increasing demand by older adults for state hospital services, the state geriatric centers are working with community psychiatric facilities to support provision of acute care in community hospitals. Over the years, the percentage of individuals admitted to state geriatric centers under TDOs increased dramatically even though community hospitals could be reimbursed for TDO admissions and Medicare could pay for the first seven of 14 days of hospitalization for patients over 65 years of age. Because community hospitals often

experienced placement issues that resulted in stays beyond 14 days, many were reluctant to accept these individuals. Community hospitals and the state geriatric centers are working closely with the Regional Utilization Management Committees to coordinate and manage transfers from community hospitals to the centers. This has enabled community hospitals to accept TDOs and provide acute treatment to individuals who otherwise would have been admitted to state geriatric centers for much longer average lengths of stay.

Goal, Objectives, and Implementation Action Steps

Goal: Increase the effectiveness and efficiency of state hospital services.

Objectives and Implementation Action Steps

1. ***Provide high quality state hospital services that efficiently and appropriately meet the needs of individuals receiving services.***
   a. Maintain sufficient numbers of trained staff in each state hospital to provide quality services that are appropriate to the populations served and assure the safety of individuals receiving services.
   b. Incorporate peer supports and active treatment that includes wellness recovery planning and educational, career development, and job training programs.
   c. Implement wellness programs designed to lower obesity, hypertension, diabetes, and heart disease and facilitate exercise and other healthy lifestyle choices.
   d. Reduce state hospital bed utilization through aggressive monitoring of service plans and discharge efforts such as targeted discharge assistance that reduce lengths of stay and enable individuals to be integrated more quickly into the community.
   e. Support the efforts of the OIG to monitor the progress of state hospitals in improving quality of care.
2. ***Improve state hospital service delivery and standardize hospital procedures as appropriate.***
   a. Conduct Annual Consultation Audits (ACAs) in each state hospital each year.
   b. Establish a mechanism to systemically address issues identified in ACA reviews.
   c. Use ACA survey results to improve state hospital treatment effectiveness and efficiency.
3. ***Reduce or divert forensic admissions from state hospitals and increase conditional releases and discharges to the community.***
   a. Enhance the Commonwealth's ability to provide outpatient forensic evaluations by:
      - Improving oversight and quality of Virginia's pretrial evaluation system;
      - Reducing unnecessary admissions for pretrial evaluation, competency restoration, and NGRI acquittees; and
      - Providing inpatient pretrial evaluation and treatment only to persons who meet emergency treatment criteria.
   b. Expand outpatient restoration services by:
      - Providing funds for outpatient restoration services; and
      - Developing a structured competency restoration treatment protocol to assure that defendants receive appropriate active treatment to restore competency in jails and community settings.
   c. Improve the flow-through of NGRI acquittees by:
      - Supporting development of community alternatives that provide a higher level of support and services, thereby decreasing the need for prolonged hospitalization;
      - Placing NGRI acquittees into the least restrictive settings necessary as quickly as possible;

- Providing enhanced access to expert consultation to help services providers address treatment-recalcitrant individuals; and
- Creating transitional housing opportunities for NGRI acquittees.

d. Provide training and resources on forensic issues to the Virginia legal community by:
   - Increasing opportunities to share training that has been developed for courts and attorneys in various regions;
   - Creating and placing informational resources for courts and attorneys on the Department's website with links to relevant model orders and case law, NGRI post-adjudication process steps, flow charts for various legal statuses, and links to relevant Departmental policy documents such as the NGRI manual; and
   - Integrating forensic issues into all Cross-Systems Mapping events.

e. Implement changes in Departmental policy regarding NGRI acquittee management to allow temporary custody of new insanity acquittees to be implemented in state hospital civil beds whenever possible based on clinical and risk status.

f. Evaluate the size maximum security unit and explore opportunities to improve its safe and secure management.

g. Improve the Department's Forensic Information System (FIMS).

4. Reduce or divert older adult admissions from state hospitals and increase discharges to the community.

a. Support development of community best practice alternatives to intensive services, including geriatric intensive treatment teams, crisis stabilization and respite care, and CSB supported assisted-living housing.

b. Provide training to long-term care facilities, primary care providers, and family caregivers on dealing with older adults with behavioral or mental health issues.

c. Supplement traditional nursing home beds in the community with behavioral health supports to allow residents to remain in their current settings.

d. Participate in cross-agency initiatives such as PACE and "Money Follows the Person" that encourage the creative use of funds to keep older adults with behavioral issues out of institutions.

5. Define the future roles and core functions of state hospitals.

a. Complete an assessment of the future need for and issues or challenges that would affect future service delivery of state hospital services.

b. Examine opportunities for public and private development of specialized community-based services for specific populations whose care has historically been provided in state hospital settings.

c. Implement best practices for regional management of inpatient resources.

E. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Effective collaboration among Virginia child-serving agencies is essential because the extent to which it exists strongly influences the success of services interventions. Children with mental health or substance use problems and their families often face a complex, multi-faceted, and rapidly evolving array of public and private providers. This includes CSBs, social services, juvenile justice, schools, and an extensive array of privately operated children's services that have developed over the past few years with public Medicaid and Comprehensive Services Act (CSA) funds.

Recently, state and local cross-agency collaboration has improved, but much more remains to be done. Through a variety of children's services system transformation efforts, Virginia child serving agencies have defined the goals, principles, and vision of an expanded and effective system of care for children and their families. The system of care philosophy,

which calls for a coordinated interagency network of services and supports that has the child and family at the center of all planning and care coordination, has been widely endorsed at the national level and in Virginia.

The system of care philosophy stresses that the best place for children to grow and develop in a healthy manner is their own family homes – or as close to their own family homes as possible. It recognizes that while some residential and inpatient services may always be needed, if a wide array of less intensive family and community-based services were commonly available, the need for residential and inpatient care could be reduced.

Even with substantial agreement across the child-serving and advocacy community regarding the need to implement system of care principles, children and families in all Virginia communities do not yet have access to a comprehensive array of services and supports. Funding limitations and restrictions have played the largest role in the failure to develop this comprehensive system, but the lack of a clear plan or guide for the development of such a system also has been a limiting factor.

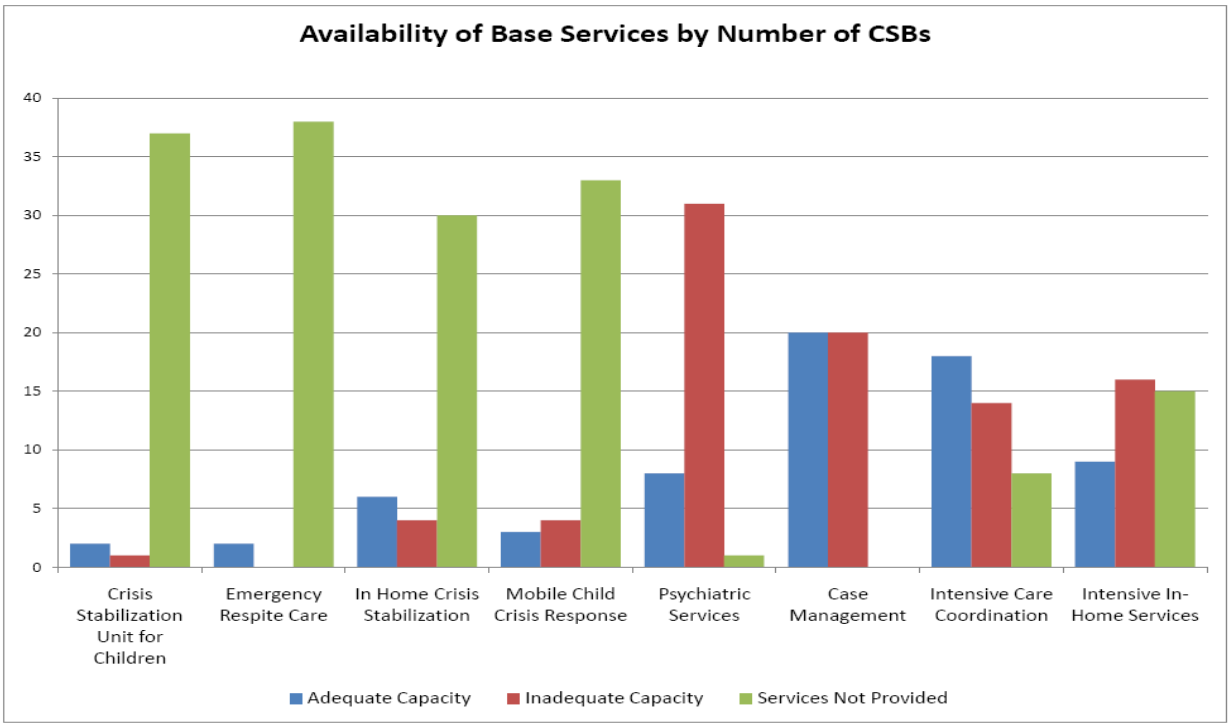
Virginia's behavioral health services system for children faces a number of challenges, the most significant of which is that children and families are faced with inadequate and inconsistent access to services and supports. No Virginia community now has the complete array of services and in many communities, the array and capacity of these base services, as depicted on the following graph, is lacking or inadequate. Limited access to services is further exacerbated because access to some services is dependent on a specific funding source. Even in communities with a good array of services, some families cannot access needed services for their children because they are not covered by Medicaid or their child is not in the CSA-mandated category.

The lack of community-based services has caused an over-reliance on inpatient and residential treatment services for children. While inpatient care is an essential component of the comprehensive service array, its restrictiveness and cost necessitate using it only when there is no other appropriate alternative. The Commonwealth Center for Children and Adolescents (CCCA) provides high quality inpatient services for the most challenged and traumatized children in Virginia and works with communities to return these children to their homes in the shortest clinically feasible time. Inpatient services provided by CCCA will be needed for the foreseeable future and until adequate and appropriate community-based services are in place.

The 2010 General Assembly directed the Department to establish a comprehensive plan to "identify concrete steps to provide children's mental health services, both inpatient and community-based, as close to children's homes as possible." The Department's interim report submitted to the General Assembly in October 2010 found that a comprehensive service array to support a child-centered, family-focused system of care is not consistently available in all areas of the state and that even when services are available there is not sufficient capacity. This comprehensive array includes 30 services in the following categories:

- Assessment and Evaluation;
- Outpatient or Office Based Services;
- Case Management and Intensive Care Coordination;
- Home and Community-Based Services;
- Intensive Community Supports;
- Community Crisis Response Services;
- Residential; and
- Inpatient Services.

Filling gaps in the comprehensive array of services would enable communities to appropriately, safely, and effectively serve children with behavioral health problems in their homes and communities. If all of these services were available, children could be served sooner and closer to home. Earlier intervention with appropriate services and supports would lessen the severity of their conditions, strengthen their family and community supports, and reduce the need for care in inpatient or residential settings. However, a 2011 Department survey of CSBs found limited availability of the following base services in the comprehensive array of services.



Because rapid widespread development of the full service array is not realistic, the Department's final report to the General Assembly, *A Plan for Community-Based Children's Behavioral Health Services in Virginia* (2011), identifies the following base services as immediate priorities for community services capacity investment.

- Crisis Response Services, including crisis stabilization, emergency respite, in-home crisis stabilization, and mobile child crisis response;
- Case Management and Intensive Care Coordination; and
- Psychiatric Services

While all CSBs provide emergency services, very few provide services that actually stabilize crises and allow children to stay with their families, or in safe family-like environments in their communities. Crisis stabilization services should be available as alternatives to inpatient care and to intervene early before more restrictive alternatives are necessary.

All CSBs provide some case management for children but many do not have the low caseload and intensive levels of support for high-need children and families. For intensive care coordination, the level of intensity requires a caseload of 7 to 12 children and an experienced case manager.

Greater availability of child psychiatrists, nurse practitioners, and medication management and development of collaborative physician networks among psychiatrists, pediatricians, and primary care providers are essential to addressing the needs of children with mental

health or substance use problem. In areas without child psychiatrists, access can be enhanced through expanded telemedicine technology.

Although intensive in-home services are widely available statewide, through a combination of CSB and private providers, there are significant issues with quality. The Department of Medical Assistance Services is working with the Department, CSBs, and private providers to improve the quality of this service. In addition, new requirements for CSBs to complete an independent clinical assessment prior to the initiation of intensive in-home, therapeutic day treatment and certain residential services are expected to improve quality by assuring that children get the right service at the right time.

A critical issue facing the services system is the inability of public and private services providers to recruit and retain qualified children's behavioral health professionals. This challenge will be exacerbated as additional services capacity is brought on line. There are areas of training expertise in Virginia, including the CCCA, some CSBs, public and private community providers, and colleges and universities. However, there is no coordinated approach to training that could harness and share this expertise. A statewide children's behavioral health workforce development initiative, implemented in collaboration with Virginia colleges and universities and provided with other child-serving agencies, would enhance public and private provider expertise in implementing the system of care philosophy and providing crisis response and other services that reduce reliance on more restrictive and costly care.

The Department does not have sufficient capacity to systemically monitor care provided in order to assure that children receive the appropriate levels and types of services to meet their needs in a timely manner. Nor does it have reliable, accurate, and consistent data to document and evaluate children's mental health service efficiency and effectiveness across all providers and agencies. Quality management and quality assurance mechanisms are needed to improve cross-agency coordination among the public child serving agencies and with private providers and address quality challenges in areas such as Medicaid-reimbursed intensive in-home services.

Goal, Objectives, and Implementation Action Steps

Goal: Enhance access to the full comprehensive array of child and adolescent behavioral health services as the goal and standard in every community.

Objectives and Implementation Action Steps

1. Increase the statewide availability of a consistent array of base child and adolescent mental health services.

a. Submit a plan to the 2012 General Assembly of needed investments over the next several biennia to improve child and adolescent mental health service accessibility.

b. Expand the array and capacity of children's behavioral health services to assure a consistent level of base services statewide.

c. Enhance linkages with partner agencies to fill gaps and build community capacity for children and youth who need behavioral health services and supports.

d. Continue the current role of the Commonwealth Center for Children and Adolescents for the foreseeable future.

2. Implement a children's behavioral health workforce development initiative.

a. Support training efforts across child-serving systems to increase consistency in public and private providers' knowledge and skills and support implementation of a comprehensive service array in a manner consistent with best practice standards.

b. Increase the number of fellowships to increase the numbers of child psychiatrists, child psychologists, and other difficult-to-recruit clinicians practicing in Virginia.

3. Establish quality management and quality assurance mechanisms to improve access and quality to behavioral health services for children and families

a. Create a quality assurance process to monitor care and assure that children most in need have access to services.

b. Create the capacity in the Department to analyze state and produce reports to inform the quality monitoring process.

Developmental Services and Supports

A. Developmental Services and Supports Capacity

The Department works in partnership with state and local agencies and public and private developmental services providers to support and affirm all persons with intellectual disability and their families as participating and contributing members of the communities in which they live. The emergence of person-centered philosophy serves as a foundation for supporting individuals with disabilities in Virginia. This philosophy stresses processes and structures that support choice and the development of plans that help people attain what is important to them while addressing issues of health and safety.

The Department, in cooperation with the Partnership for People with Disabilities, continues to be actively involved in providing leadership to expand person-centered practices through targeted systems changes, training, and ongoing collaborative efforts with DMAS, public and private providers, and other stakeholders. Two federal Centers for Medicare and Medicaid Services (CMS) funded multi-year interagency projects, the Real Choices Systems Transformation grant and the Money Follows the Person demonstration grant, are working to give individuals more informed choices and options about where they live and receive services and to support the transition of individuals from institutions to community-based alternatives. By June 2011, the Money Follows the Person project had moved 26 individuals from nursing homes, 7 individuals from long-stay hospitals, 28 from community ICFs, and 89 individuals from training centers into more homelike community settings. The Systems Transformation Grant supports a partnership with DMAS, the Partnership for People with Disabilities, DSS, and other agencies that has provided cross-systems person-centered training, designed new electronic systems for managing information, and improved methods of delivering necessary information to families in need of services.

Person-centered planning practices have been incorporated into the Medicaid home and community-based Intellectual Disability (ID) and Day Support (DS) Waivers. A uniform person-centered planning format and process is being used to develop individualized support plans for individuals in community and training center environments. An internationally recognized Person Centered Thinking (PCT) training curriculum, *The Learning Community*, is being implemented and a PCT mentoring capacity has been established to provide coaching and facilitated training, as needed, to develop and sustain person-centered practices. The Department has initiated a multi-year roll-out of the *Supports Intensity Scale*™ (SIS™), one of the first person-centered individual needs assessments for persons with developmental disabilities, across the Medicaid-funded services system in community services and training centers and is training professionals on elements of a Person-Centered Individual Service Plan such as writing outcomes, measuring and documenting progress, clarifying and personalizing support instructions, quarterly reviews, and documenting safety supports.

Virginia has added 2,876 community, facility, and MFP ID Waiver slots since FY 2004 with start-up funds accompanying each slot funded through FY 2009 to help increase the capacity of the community to provide adequate supports. The DS Waiver, established in FY 2006 to offer Day Support, Prevocational, and Supported Employment services to individuals on the Waiver urgent and non-urgent waiting lists, remains at its original

allocation of 300 slots. The 2011 General Assembly funded 275 additional ID Waiver slots and 150 additional Individuals and Families with Developmental Disabilities Supports (IFDDS) Waiver slots beginning July 1, 2011, for a total of 8,937 ID waiver, 300 day support waiver, and 770 IFDDS waiver slots. Although the Commonwealth has consistently identified funds to expand the number of waiver slots, Virginia is currently faced with a waiting list of approximately 7,000 individuals for ID and IFDDS waiver slots.

Pressures to increase community services capacity will continue as the approximately 2,000 students who graduate annually from special education classes seek ID waiver or other more flexible developmental services such as intermittent or limited supports to ease their transition from special education programs. Growing numbers of individuals with aging care givers also will require developmental services and supports to enable them to continue to reside in their homes or other community placements.

Community providers of developmental services are serving proportionately greater numbers of individuals with significant and complex needs that require specialized services and supports. The current ID Waiver does not provide the level of supports and reimbursement rates for targeted services that would make it a truly effective alternative for individuals with needs for high intensity services. Waiver reimbursement rates do not consistently promote services with the highest social value (e.g., employment), the most person-centered outcomes (e.g., smaller residential options and community-based day support), or the most effective means of supporting individuals with extensive medical or behavioral needs. The Department continues to advocate with DMAS for improvements to and increased flexibility for existing waivers and for the creation of new waivers that would provide a new supports capacity and high intensity services.

The capacity of the services system to provide medical, dental, and behavioral supports in the community as close to individuals' homes as possible also needs to be strengthened. For individuals with intellectual disability, challenging or difficult-to-manage behaviors can adversely affect their abilities and opportunities to participate fully in any aspect of community life and may pose a threat of serious harm to themselves or others. Without appropriate community-based interventions, these individuals may be at increased risk for psychiatric hospitalization because they require specialized supports in a secure environment or placement in a state training center or community ICF/ID facility.

Although diversion of long term admissions and development of community capacity has reduced the average daily census of the training centers over the past six years, there continues to be an imbalance in resources available for developmental services. The current a dual system continues to support both institutional and community models of support. A new way of supporting individuals is required if Virginia is to adequately meet future demand for services and supports.

In its report on the investigation of CVTC, the U.S. Department of Justice (DOJ) has made it clear that it is expecting to see more aggressive initiatives to insure that adequate community support services are made available for individuals as real alternatives to institutional placements and that segregated institutions do not play significant roles in the services and supports systems of the Commonwealth. The 2011 General Assembly allocated $30 million for a trust fund to help individuals transition from training centers to community programs and five Department positions to help in transitioning individuals from training centers to community programs. It also provided $5 million for crisis intervention programs for individuals with intellectual disability and co-occurring mental health disorders.

Transformation to a community-focused system of developmental services and supports will continue to cause dramatic increases in the number of licensed providers of community developmental services. This increase in new providers and emerging evidence-based practices will require additional quality assurance and management oversight. The

Department must strengthen its quality management and administrative capacity to provide oversight, training, and technical support necessary to ensure provider compliance with regulations and standards of quality. Quality varies greatly among providers of Medicaid Waiver services and many providers are not aware of best practices. State and partner agency training resources are limited generally, including Department central office training and technical support capacity for new providers and to improve staff competencies across the spectrum of support service delivery.

Goal, Objectives, and Implementation Action Steps

Goal: Build community services and supports capacity that will enable individuals who need developmental services and supports to live a life that is fully integrated in the community.

Objectives and Implementation Action Steps

1. Improve provider coordination and planning of services and supports.

a. Implement the Supports Intensity Scale™ and person-centered planning practices statewide for individuals receiving developmental services.

b. Establish a system to use information about identified services and supports needs of individuals in training centers and on current wait lists to build community capacity.

2. Build community services and supports capacity.

a. Develop community-based developmental services and supports to implement agreed upon agreements with the DOJ.

b. Develop implementation strategies for allocating the $30 million Trust Fund established in §37.2-319 to address DOJ findings based on agreed-upon plans.

c. Establish a crisis management system in every community, beginning with the initial ID crisis response programs funded by the 2011 General Assembly.

d. Collaborate with DMAS to expand waiver capacity, modify existing or create new waivers, and address waiver rate structures.

e. Develop community respite alternatives to training centers.

f. Develop specialized medical, dental, behavioral, and other clinical services in the community and expand access to non-specialized community practitioners.

g. Expand family supports and other initiatives that allow individuals to have control over how their service dollars are spent.

3. Enhance the effectiveness and efficiency of state training center services.

a. Continue to reduce training center bed utilization through aggressive monitoring of service plans and discharge efforts that enable individuals to be integrated more quickly into the community.

b. Maintain sufficient numbers of trained staff in each training center to ensure quality services that are appropriate to the populations served and maintain resident safety.

c. Continue to implement strategies in each training center that facilitate person-centered planning and promote self-determination and community participation.

d. Implement the Annual Consultation Audit (ACA) process in training centers.

4. Improve the quality and effectiveness of developmental services.

a. Continue to provide training to providers on developing person-centered environments for individuals with intellectual disability and their families.

b. Enhance central office administrative infrastructure to provide training and technical assistance, oversee and monitor existing programs' performance and services recipients' outcomes, and maintain compliance with CMS expectations.

B. AUTISM SPECTRUM DISORDER AND DEVELOPMENTAL DISABILITIES SUPPORTS AND SERVICES

The 2008 General Assembly directed the JLARC to examine the services available to Virginians with autism spectrum disorders (ASDs). Its report, *"Assessment of Services for Virginians with Autism Spectrum Disorders"* (House Document No. 8, 2009), stated that approximately one out of every 150 eight-year-olds enrolled in Virginia public schools in 2007 had been classified with an ASD and had received special education services for that disorder. This represented an increase of more than 400 percent in students with ASDs between 1998 and 2006. Although several theories were discussed, JLARC noted that the cause of this dramatic increase is not clear.

The JLARC report described several public programs that diagnose, treat, and manage ASDs but found that they tended to be inadequately coordinated and did not fully address the needs of Virginians with ASDs. The report included detailed recommendations that focused on coordinating and funding ASD services in Virginia, including:

- Promoting ASD early detection through a statewide public service campaign, ASD screening in non-clinical settings that come into contact with young children (e.g., local departments of social services, day care centers, and Head Start/Early Head Start), and use by pediatric and family physicians of standardized developmental screening tools for all developmental delays, including autism;
- Establishing CSBs at the single point of entry for the developmental services system, including services to individuals with an ASD;
- Realigning and increasing administrative coordination between the ID and Individual and Family Developmental Disabilities Waiver Services (IFDDS) waivers and determining the need for and cost of a Medicaid respite waiver to provide minimum services to children with developmental disabilities (DD) who meet waiver level of functioning criteria;
- Increasing family and individual supports for individuals who are not currently receiving or are ineligible to receive ID or IFDDS waiver services;
- Promoting a well-qualified community-based workforce and develop provider skills;
- Increasing knowledge of access to long-term employment supports and improve the employment skills and opportunities for adults with an ASD; and
- Considering the role of private insurance in covering autism treatment.

The Department is providing leadership interagency planning to address the JLARC report recommendations. Through two specialist positions established in 2009 and other Creating Opportunities strategic initiatives, the Department is working with DMAS to provide services and supports that will benefit these populations. The Department is partnering with the Virginia Commonwealth University Autism Center for Excellence to disseminate ASD best practices and is providing or supporting training for public and private providers, schools, vocational counselors, public safety officials, and other health professionals.

The 2011 General Assembly passed a bill providing insurance coverage for autism and established an Autism Advisory Council with legislative and citizen members and ex officio state agency and university representatives. This Advisory Council will help oversee the development of ASDs supports and services to Virginians. Demand for these supports and services is significant and will escalate over the next six years as the rapidly growing number of children identified with an ASD that are now receiving special education services leave schools systems.

Goal, Objectives, and Implementation Action Steps

Goal: Incorporate services and supports for individuals with autism spectrum disorders or developmental disabilities in Virginia's developmental services delivery system.

Objectives and Implementation Action Steps

1. ***Define and coordinate developmental services system responsibilities for ASD and DD supports and services.***
   a. Develop an implementation plan to advance the recommendations in *"Assessment of Services for Virginians with Autism Spectrum Disorders"* report.
   b. Develop or update memoranda of agreement for ASD and DD service coordination with the Departments of Education, Rehabilitative Services, Health, Social Services, Medical Assistance Services, and Criminal Justice Services.
2. ***Enhance community awareness of and access to ASD and DD supports and services.***
   a. Collaborate with DMAS to expand waiver capacity, modify existing or create new waivers, and address waiver rate structures.
   b. Support efforts with partners to provide information to the public about ASDs, offer ongoing education and additional training, and expand access to early diagnosis and intervention resources.
   c. Promote implementation of ASD evidence-based practices and services models in collaboration with the Autism Center for Excellence.
   d. Support efforts of the Autism Advisory Council.
   e. Explore opportunities for non-waiver funded ASD and DD supports and services development.
   f. Monitor the impact of the "Autism Insurance" legislation on the Part C program.

Systemwide Strategic Initiatives

A. HOUSING

The 2003 federal *New Freedom Commission on Mental Health* report stated that *"the shortage of affordable housing and accompanying support services causes people with serious mental illnesses to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing."* Safe, decent, and affordable housing is essential to recovery, and housing stability is correlated to lower rates of incarceration and costly hospital utilization. As a general rule, individuals should not spend more than 30 percent of their monthly income on housing. Monthly Supplemental Security Income (SSI) payments for an individual are $674 in Virginia while the average Fair Market Rent for a one-bedroom unit is $887. Auxiliary Grants subsidize housing for individuals receiving SSI, but are limited to Assisted Living Facilities and Adult Foster Care homes and cannot be used more flexibly in other housing arrangements. Medicaid does not pay for housing.

Between January and April 2010, 3,559 adults receiving CSB mental health services completed the Recovery Oriented System Indicators Survey (ROSI) survey, which measured their recovery experience. Only 58 percent of the respondents said they had housing that they could afford.

The 2009 Appropriation Act directed the Department to study investment models and best-practices for the development of affordable and accessible community-based housing for persons with intellectual and related developmental disabilities. This study, presented to the General Assembly in late 2009, identified housing and support alternatives to increase the availability of community housing, leverage state dollars, and promote individualized, person-centered options for individuals with developmental disabilities. Executive Order 10 (2010) describes housing as a major component in determining quality of life for Virginians. The housing policy framework and principles outlined in the Executive Order speak to the importance of:

- Promoting sustainable and vibrant communities, including expanding public-private cooperation in addressing affordable safe housing;
- Ensuring a range of housing options to meet the housing needs of changing populations, including promoting a continuum of quality housing options for special needs populations, matching existing subsidies with areas of housing need, and increasing emphasis on fair housing and eliminating barriers to housing; and
- Increasing capacity to address the needs of homeless Virginians, including focusing on the reduction of chronic homelessness, ensuring the continued viability of the safety net of shelters and services, and investing in transitional and permanent supportive housing.

Permanent supportive housing does not place limits on a person's length of tenancy as long as he or she abides by the conditions of the lease or agreement. The person has access to a flexible array of comprehensive services, including medical and wellness, mental health, substance use management and recovery, vocational and employment, money management, case management, life skills training and assistance, household establishment, and tenant advocacy. However, use of services or programs is not a condition of ongoing tenancy. The permanent supportive housing model involves a working partnership that includes ongoing communication between supportive services providers, property owners or managers, and housing subsidy programs. Under the model, the person would pay no more than 30 to 50 percent of household income towards rent.

Historically, the behavioral health and developmental services system has tied housing to services. Highly intensive, intensive, and supervised residential services provide overnight care with varying levels of treatment or training services and supervision. The exception is supportive residential services, which enable individuals to live in their own housing arrangements. In 2010, the State Board of Behavioral Health and Developmental Services updated its housing policy, Policy 4023 (CSB) 86-24, to include the following principles:

- Individuals should live in stable, decent, and affordable housing of their choice;
- Appropriate, flexible, accessible, and effective support services should be available;
- Housing should be available in integrated settings throughout the community; and
- To ensure choice, the behavioral health and developmental services system has the responsibility to facilitate access to existing housing and stimulate the preservation and development of housing.

The Department is participating on the Homeless Outcomes Advisory Committee, established under Executive Order 10 to expand supportive housing, including specialized housing, and improve discharge policies and procedures of jails, hospitals, and the mental health system, and increase flexibility of funding.

Goal, Objectives, and Implementation Action Steps

Goal: Address housing needs for individuals with mental health and substance use disorders and those with developmental disabilities.

Objectives and Implementation Action Steps:

1. Support implementation of the Governor's Housing Initiative recommendations.

a. Participate in cross secretarial and interagency activities to:
   - Leverage state and federal funds for housing for individuals with special needs,
   - Establish and align state priorities and program resources,
   - Expand access to non-institutional community housing options, and
   - Address local barriers to affordable housing.

b. Participate as a member of and support the Governor's Homeless Outcomes Workgroup efforts to:

- Expand permanent supportive housing,
- Prevent homelessness and support rapid re-housing,
- Increase statewide data collection and coordination,
- Increase access to behavioral health services, and
- Strengthen discharge policies and protocols.

c. Expand the capacity of public and non-profit homeless services providers to connect individuals receiving services to SSI/SSDI benefits by implementing the SSI Outreach and Recovery (SOAR) evidence-based practice and providing technical assistance and training to homeless services providers.

d. Promote creation of additional Housing First Projects.

2. Establish housing stability as a goal of the behavioral health and developmental services system.

a. Include housing stability as a systemic performance measure in the Department's Performance Contract with CSBs.

b. Create, in partnership with CSBs, a mechanism for reporting housing-status change information monthly for individuals receiving CSB case management services and analyze their length of housing tenure and frequency of moves.

c. Develop and monitor benchmarks and housing stability outcomes for individuals receiving services.

3. Expand housing and supports options for individuals receiving behavioral health and developmental services.

a. Adopt updated memoranda of agreement with the Department of Housing and Community Development and the Virginia Housing Development Authority that formalize interagency work to increase integrated community housing options.

b. Develop strategies to implement the State Board housing policy, including promotion of individual preferences and permanent supportive housing.

c. Provide training and consultation to CSBs and other public and non-profit services providers on how to access and leverage federal resources for housing and community-based supports and implement the supportive housing model.

d. Develop or provide access to affordable housing with appropriate supports for individuals with mental health, substance use, or co-occurring disorders.

- Establish and sustain regional planning and collaborative coalitions of CSBs, public housing authorities, planning district commissions, and local housing organizations that implement the supportive housing model.
- Review approaches for leveraging housing resources used in other states such as the Tennessee Creating Homes Initiative.
- Continue dialogue and planning efforts with DMAS to explore the potential extension of the MFP program to individuals with behavioral health disorders who are transitioning from state hospitals.

e. Establish and implement community-based housing options for individuals receiving developmental services that reflect Virginia's "person-centered" vision.

- Explore opportunities to "decouple" developmental services and supports provision and housing.

B. EMPLOYMENT

People who are employed improve their sense of self worth and contribute to the economy. There are interventions that have been proven to help adults with a serious mental illness transition from income subsidies to successful competitive employment, but as the *New Freedom Commission on Mental Health* (2003) reported, *"Disturbingly, most vocational*

rehabilitation services are ineffective for the small proportion of people with mental illnesses who manage to get them." The 2010 Recovery Oriented System Indicator (ROSI) survey of 3,559 adult CSB mental health service recipients measured perceptions of how well the service system supported them in recovery. Help with getting and keeping employment was found to be one of the most significant factors in whether respondents scored the system as having a recovery orientation.

The U.S. Surgeon General reported in 1999 that unemployment rates among adults with a serious mental illness run as high as 90 percent. Today, CSBs report full or part-time employment rates of only 14 percent among adults receiving mental health services with serious mental illness, 32 percent among adults receiving substance abuse services, and 16 percent among adults receiving developmental services. These low employment rates occur despite surveys that show that many adults with behavioral health disorders or developmental disabilities do want to work, but they are more likely to be unemployed than are persons with other disabilities.

Adults with serious mental illness make up the single largest diagnostic group (35 percent) on the Supplemental Security Income (SSI) rolls and over one quarter (28 percent) of all Social Security Disability Income (SSDI) recipients. A significant portion of special education students and families believe that if they work, they will lose their SSI benefits. Also, there is a significant lack of awareness of work incentives under SSA for SSI or SSDI recipients. Navigation through the work incentives and benefits available through SSA is laborious and very difficult to achieve in isolation.

Persons with intellectual disability are more likely to be unemployed than are persons with other disabilities. The return on investment in long term employment supports for individuals with intellectual disability is for every one dollar spent on services three dollars in income is generated. The Department has joined the National Association of State Directors of Developmental Disabilities Services, which sponsors the Supported Employment Leadership Network (SELN) project. SELN provides training opportunities designed to develop and promote supported employment initiatives. The Department is working in partnership with the Virginia SELN to promote "employment first" awareness and policy changes for the state's developmental and behavioral health services system. "Employment first" emphasizes person-centered planning and, for individuals where employment is an appropriate and viable option, integrated and supported employment over sheltered employment with sub-minimum wages or non-work day activities.

Goal, Objectives, and Implementation Action Steps

Goal: Create employment opportunities for individuals with mental health or substance use disorders and those with developmental disabilities.

Objectives and Implementation Action Steps

1. Establish and implement employment first as the policy of the Commonwealth.

a. Develop a new State Board policy that promotes employment opportunities for individuals receiving behavioral health or developmental services.

b. Conduct a statewide employment first awareness and education campaign.

c. Use state, regional, and local trainings to expose employers to new innovative employment models and train them in how to assist challenging individuals.

d. Conduct workshops to develop cross-agency implementation strategies.

2. Establish employment outcome expectations as a goal of the behavioral health and developmental services system.

a. Include the goal of gaining or maintaining meaningful employment of adults receiving services as a desired outcome in the Department's Performance Contract with CSBs.
b. Create, in partnership with CSBs, a mechanism for monitoring change in CSB service recipients' employment status and reporting key employment outcome indicators established in the employment policy to the Department.
c. Develop and monitor employment benchmarks and outcomes for adults receiving CSB services.

3. Expand employment opportunities for individuals receiving behavioral health or developmental services.

a. Expand supported employment evidence-based practice models.
b. Provide training and consultation to services providers on implementing new innovative supportive employment practice models and establishing integrated supported employment teams that include CSBs, DRS, and employment services organizations (ESOs);
c. Partner with DRS to provide cross-training for respective staff focused on increasing access to vocational services, job training, and employment supports for individuals with mental health or substance use disorders.
d. Work with DRS to expand Long-Term Employment Support Services (LTESS).
e. Increase access of individuals, family members, case managers, and public and private vocational and employment-related services providers to accurate information on existing SSI and SSDI work incentives and SSA individualized benefits assistance planning through:
    - Benefits training;
    - Access to qualified work-related incentives/benefits counselors; and
    - Use of the VCU Employment Support Institute's WorkWORLD™ software.
f. Work with DMAS to incorporate supported employment evidence-based practice models in Medicaid Day Support, Mental Health Support Services, and Psychosocial Rehabilitation regulations.
g. Work with DMAS to incentivize integrated employment in the ID and IFDDS waivers.
h. Continue to train and certify CSB and IFDDS waiver case managers in each region as work incentive counselors.
i. Identify and, as appropriate, collaborate with DRS and other entities on federal and other grant opportunities for enhancing employment services, supports, and outcomes for individuals with mental health or substance use disorders.

3. CASE MANAGEMENT

Virginians with mental health or substance use disorders or intellectual disability receive case management (service coordination and intensive case management) to help them navigate and make the best use of the publicly funded system of services. This includes connecting with the right level and intensity of services and providing day to day support to assure stable community living.

The behavioral health and developmental services system uses the term case management to cover a broad array of services and supports. A Creating Opportunities Case Management workgroup was established by the Department in June 2010 to define core competencies for case managers. Its final report to the Department, March 2011, stated:

> *The term "case management" is used to cover a broad array of services, from temporary to intermittent activities performed by clinicians and others in coordinating behavioral health care, to long-term wraparound direct services provided by specified case managers. Similarly, the preferred term for such long-term*

comprehensive services for individuals with an intellectual disability is "support coordination" and in children's mental health services, it is called "care coordination" or "service coordination." In further confusion, managed care entities and insurance companies use the term "case management" in describing activities that are often limited to assessing the need for and authorizing access to medical or behavioral health care (e.g., care coordination in a managed care environment).

The workgroup, which included representatives from CSBs and private providers, family and peer groups, the Department of Medical Assistance Services (DMAS), and the Department, recommended that the Department, CSBs, and DMAS uniformly adopt the following definitions of care coordination, basic case management, and targeted case management.

- ***Care Coordination:*** Includes management and brokering of services for individuals to ensure that needs are met, covered services are not duplicated by the care-providing organization(s), and resources are used most cost effectively. It primarily involves gate-keeping functions, such as approving care plans and authorizing services, utilization management, providing follow-up, and promoting continuity of care.
- ***Basic Case Management:*** Includes assessing the needs, wants, strengths and preferences of individuals seeking services and supports; creating a viable plan to assist in referring to, accessing, and utilizing needed services and supports; actively monitoring the delivery of services and their outcomes; supporting and assisting to address unmet needs; and collaborating and coordinating with others to ensure effectiveness and avoid duplicative services.
- ***Targeted Case Management****:* Includes the elements of Basic Case Management and a full range of care and support that individuals with more severe disabilities require in order to live successfully in the community. These services include: supportive counseling; crisis intervention; direct assistance with limited activities of daily living; coaching; intake and discharge planning; relationship building; teaching decision making; self-advocacy, and wellness planning; educating regarding the need for medications, primary care, and therapy; promoting continuity of care among various health systems and providers; providing family education and support and generally overcoming barriers for accessing appropriate care.

Strengthening the case manager's role and core competencies is essential to ensure that case managers have the knowledge and expertise needed to provide effective and accountable services and identify and strengthen the individual's natural support systems. Because individuals with more serious disabilities are being served in the community, case managers are providing more supportive counseling and crisis intervention, coordinating more complex plans of care and support, and spending more time monitoring the effectiveness of an entire range services to help prevent the need for more intensive and expensive interventions. The Case Management Workgroup identified the following core case management competencies:

- ***General Competencies:*** Cultural and linguistic competence, safety, ethics, and use of technology; and
- ***Case Management-Specific Competencies:*** Job knowledge, assessment skills, service planning and service access, advocacy, interpersonal and team skills, judgment and analytic ability, adaptability, and organizational skills.

The absence of appropriate workforce development for case managers and inconsistent practice standards or core competencies has resulted in wide variation across communities in the level and quality of case management experiences for individuals and families and a limited ability to assess competency and measure outcomes. The OIG's 2006 *Review of Community Services Board Mental Health Case Management Services for Adults* and its 2007 *Review of Community Services Board Mental Retardation Case Management Services*

for Adults found that case managers receive little training in topics specifically related to case management. It reported that few, if any, new case managers enter employment at CSBs with formal training or professional preparation to be a case manager.

The Case Management Workgroup identified specific training topics to address basic and disability-specific case management competencies and recommended that the Department and CSBs establish a case management curriculum committee to work with a curriculum development expert to assess existing training modules for their suitability in addressing case management competencies and identify and develop additional curriculum and testing needed to address the core and disability-specific competencies.

Virginia does not have a system for assuring that the persons who provide case management have the knowledge and skills needed to be effective. The workgroup recognized the need to establish a system that would consistently and formally recognize the competencies of each case manager. To achieve this, it recommended that the Department establish a uniform case management certification with basic and advanced disability-specific levels that would apply to case managers in the behavioral health and developmental services system statewide.

Goal, Objectives, and Implementation Action Steps

Goal: Strengthen the capability of the case management system to support individuals receiving behavioral health or developmental services.

Objectives and Implementation Action Steps

1. Enhance the core competencies of persons who provide case management services.

a. Establish a case management curriculum workgroup comprised of Department and CSB representatives who will work with the curriculum development expert to:
   - Review existing training modules identified by the Case Management Workgroup for their suitability in addressing case management competencies;
   - Assess gaps in existing training modules based on the outline of basic and disability-specific training topics developed by the Case Management Workgroup
   - Identify training modules that would need to be developed; and
   - Recommend a curriculum of existing and new training modules that address case management core competencies to the Department.

b. Adopt a curriculum for basic and disability-specific case management levels.

c. Create case management training modules.

d. Work with provider groups to implement the case management training curriculum.

2. Promote consistency in the practice of case management across Virginia.

a. Explore options for formally recognizing the competencies of each case manager in the behavioral health and developmental services system.

b. Identify regulatory or other prerequisite requirements for case manager certification.

c. Define case manager certification experience, training, and testing requirements.

d. Create and pilot basic and advanced disability-specific case management certification tests based on competency requirements.

e. Establish a case management credentialing process to administer tests, certify and recertify case managers, and maintain certification databases.

f. Work with provider groups to begin implementation of case management credentialing process.

VII. DEPARTMENT INITIATIVES

Services System Quality Improvement and Accountability

As Virginia's system of public behavioral health and developmental services is transformed, the services system must take proactive steps to create and sustain a culture of recovery, self-determination, and person centered planning. The Department performs a number of oversight and accountability activities, including:

- Licensing of all behavioral health (mental health and substance use disorder), developmental services, developmental disability waiver, and residential brain injury services to ensure that providers meet and adhere to regulatory standards of health, safety, service provision, and individual rights;
- Protecting individual human rights through a statewide program established to protect the fundamental rights of individuals receiving services from state facilities and services licensed or funded by the Department;
- Complying with Agency Risk Management and Internal Controls (ARMICS) Standards pertaining to compliance with laws, regulations, and practices that assure appropriate stewardship over the Commonwealth's assets; and
- Conducting CSB program reviews and state hospital annual consultative audits.

In addition, the Inspector General for Behavioral Health and Developmental Services (OIG) reviews services provided in state facilities and by licensed providers, including CSBs, private providers, and DOC mental health units. The OIG provides its findings to the Governor and General Assembly and publishes its reports on its website.

To support systems change, the Department has established a quality improvement process that focuses on CSB progress in advancing the core elements of the vision of recovery, self-determination, health, and community participation and emphases best practices. Through this process, the Department intends to identify a limited number of behavioral health and developmental services measures, based on the following considerations:

1. Quality improvement data should measure **meaningful outcomes**. The Department would measure the outcomes but it would be up to individual CSBs to change their business processes to improve their outcomes. While the focus should be on outcomes rather than on the processes to achieve those outcomes, some process measures such as days waiting to enter treatment that support recovery or the Creating Opportunities Plan may be important measures from a policy perspective.
2. For the initial measures, **current available data** should be used. Once the process is established with some initial successes, collection of other data would be considered.
3. Data should be **timely**, with data analysis and feedback provided to CSBs at least quarterly and possibly more often depending on Department staff and IT resources.
4. Measures should be **clear, accessible, comparative, and understandable**. They should be presented in a manner that is easy for the reader to understand (e.g. listing results from best to worst rather than alphabetically). Detailed or complex explanations of the data should be avoided.
5. Measures should **focus on systemic measurements** at the CSB level, not on changes at the individual receiving services level.

The Department plans to defer developmental services measures in light of DOJ activities and to instead focus on the following behavioral health quality improvement measures, which will be reported quarterly for the previous 12 months.

Mental Health Recovery Measures:

- **PACT Outcomes:** Percent of individuals participating in a Program of Assertive Community Treatment (PACT) with stable housing, low psychiatric hospitalizations, and no arrests;
- **Employment Status:** Percent of admitted who met the criteria for serious mental illness and received at least one mental health case management service who were employed full- or part-time or received supported employment services; and
- **Intensity of Engagement by Adults in Community Mental Health Case Management Services:** Percent of adults admitted who met the criteria for serious mental illness and received one hour of mental health case management services within 30 days of admission who received at least five additional hours of mental health case management services within 90 days of admission.

Substance Abuse Services Measures

- **Intensity of Engagement by Adults in Community Substance Abuse Outpatient Services:** Percent of adults admitted who received one hour of substance abuse outpatient services after admission who received at least two additional hours of substance abuse outpatient services within 30 days of admission;
- **Retention in Community Substance Abuse Services:** Percent of all individuals admitted to the substance abuse services program area who received at least one substance abuse or mental health service in the month following admission who received at least one mental health or substance abuse service every month for at least the following five months; and
- **Days Waiting to Enter Community Substance Abuse Treatment:** For all individuals admitted to the substance abuse services program area, the average number of calendar days from the date of the first contact or request for service until the first scheduled appointment in a substance abuse service accepted by the individual.

Children's Mental Health Services Measures

- **Intensity of Engagement by Children in Community Mental Health Outpatient Services:** Percent of children admitted who received one hour of mental health outpatient services within 30 days of admission who received at least two additional hours of mental health outpatient services within 30 days of admission.

Goal, Objectives, and Implementation Action Steps

Goal: Enhance the capacity of the behavioral health and developmental services system to improve quality of care.

Objectives and Implementation Action Steps

1. Implement a systemwide quality improvement process.

a. Work with the CSBs and other stakeholders to design and implement quality improvement measures with measurable and realizable implementation processes.
b. Support state facility self-monitoring and continuous quality improvement processes.
c. Track and publish quality improvement measures on the Department's website.
d. Work with CSBs and state facilities to improve the quality of measurement data.

2 Increase the effectiveness and efficiency of the Department's licensing program.

a. Continue to identify program efficiencies to increase the time that licensing specialists have available to perform inspections, issue licenses, and respond to complaints.
b. Continue to make improvements in applicant training.

3. Increase the effectiveness and efficiency of the human rights system.

a. Identify program efficiencies that would increase the time that advocates have available for direct involvement with individuals receiving services.

b. Continue to make improvements in the current human rights organizational structure.

c. Provide guidance and technical assistance on the regulations aimed at promoting treatment in the most integrated settings and enhancing individual decision-making.

Electronic Health Records and Health Information Exchange

In 2009, Congress passed the *American Recovery and Reinvestment Act*. This broad legislation addresses a large variety of healthcare issues, one of which is the requirement for health care providers to implement an electronic health record (EHR) system. With its operation of multiple facilities in various locations, the Department recognized that implementation within a short period of time would be problematic and decided to use a phased EHR implementation process in state facilities. The Department's EHR billing module (AVATAR) is complete and implementation of the remaining modules must be completed by 2014 if the Department is to continue to bill Medicaid and Medicare.

A primary consideration when planning for an EHR system is the need for the system to be capable of integration with other Department systems, including AVATAR. Additionally, CMS has extended the Medicaid Information Technology Architecture (MITA) to cover a broad array of safety net services, including behavioral health, and results from this assessment must be incorporated into the Department's EHR planning. Finally, HIE considerations must be addressed to enable information and data to be exchanged among facilities, and eventually with CSBs through Commonwealth Gateway.

Federal authorities have recognized that the requirement to implement and EHR/HIE system is a costly incentive. Medicare and Medicaid have provisions that will consider retrospective incentive payments that may be applicable to the Department. This would allow the Department to build in the costs related to hardware, software, telecommunications, labor, and other related costs into the daily rates of eligible facilities (training centers and geriatric units). The Department estimates that most hardware, software, and staffing costs can be recovered through this process.

Goal, Objective, and Implementation Action Steps

Goal: Complete the phased implementation of an electronic health record across the state facility system.

Objective and Implementation Action Steps

1. Successfully implement an EHR at each state facility.

a. Perform workflow analysis in facilities to define common and unique clinical workflows across facilities and use findings to develop requirements.

b. Conduct a pilot test of the template at Hiram Davis Medical Center and modify template based on test results.

c. Prepare and issue a request for proposals and select an EHR vendor.

d. Begin EHR implementation, including ongoing project management oversight.

Cultural and Linguistic Competency

Racially, ethnically, and linguistically diverse populations in Virginia have increased significantly over the past ten years. The 2010 Census data reflects this increasing diversity.

- More than 1.5 million Virginia residents reported themselves to be black or African American, accounting for nearly 20 percent of the total population. This segment remains the largest minority group in Virginia.

- Just over 630,000 residents or 7.9 percent of the Virginia population reported themselves to be Hispanic. This is a 92 percent increase since 2000. Half of this segment is made up of individuals under age 19.
- Almost 440,000 Virginia residents or 5.5 percent of the Virginia population are Asian. This is a 69 percent increase since 2000.
- More than 233,000 Virginia residents, or 2.9 percent of the population, reported that they belong to two or more of the six race categories counted in the census: white; black or African-American; American Indian and Alaska native; Asian; Native Hawaiian and other Pacific Islander; or some other race.

Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences. In 2008, 2.8 percent of all Virginia households (both natives and the foreign born) had limited linguistic competence in English. In these households, all persons age 14 and over were linguistically isolated, with 24.5 percent speaking Spanish, 10.8 percent speaking other Indo-European languages, 23.8 percent speaking Asian or Pacific Island languages, and 15.5 percent speaking other languages.

Additionally, communication barriers associated with hearing loss can seriously impede access to CSB services, resulting in the need for specialized services and accommodations for these individuals. The Department supports specialized regional consultation and direct services to this population and continues to work closely with the Advisory Council for Services for People Who Are Deaf, Hard-of-Hearing, Late Deafened, or Deafblind, which includes service providers, state agency representatives, and advocates, to identify and evaluate the critical behavioral health service needs of this population and to recommend service improvements.

The Department's *Plan for Cultural and Linguistic Competency in Behavioral Health and Developmental Services 2011-2012* includes the following vision for culturally competent care.

- Care that is given with understanding of and respect for the individual's health-related beliefs and cultural values;
- Staff that respect health related beliefs, interpersonal styles, and attitudes and behaviors of the individuals, families, and communities they serve; and
- Administrative, management, and clinical operations that include routine assessments and implementation of processes that result in a workforce that is culturally and linguistically competent and a system that provides the highest quality of care to all communities.

In 2008, the Department established a position in the central office and a statewide steering committee to promote and improve access to behavioral health and developmental services for multi-cultural populations across Virginia. Initial work has focused on planning and developing infrastructure supports; providing outreach to and linking providers with people who could serve as cultural brokers; establishing and sustaining state and local advisory councils, recommending culturally and linguistically appropriate evidence-based treatments and practices, and training providers on the delivery of culturally and linguistically competent services.

Goal, Objectives, and Implementation Action Steps

Goal: Increase the capacity of the behavioral and developmental services system to provide culturally and linguistically appropriate services and supports to diverse populations across Virginia.

Objectives and Implementation Action Steps

1. Assess the cultural and linguistic appropriateness of services and supports provided across Virginia.

a. Review the linguistic capacity and training needs of service providers and support staff and recommend policies and protocols to address specific language needs.

b. Convene focus groups to gather assessments from individuals receiving services.
c. Engage peer-run organizations in organizational assessments.

2. Provide training and workforce development to increase the ability of behavioral and developmental services providers to serve diverse cultures of their communities.

a. Develop a webinar series for stakeholders on effective communication standards and strategies, including use of interpreters.
b. Disseminate guidance for licensed providers on the national standards on *Culturally and Linguistically Appropriate Services* (CLAS) in health care.
c. Continue to offer language access and individual and organization competence training.
d. Develop a process to distribute job announcements to diverse communities.

3. Increase the number of organizations with written plans for cultural and linguistic competency.

a. Develop a marketing strategy and training to promote plan development.
b. Offer training related to plan development.

4. Increase the services system capacity and infrastructure for delivering services to individuals and families with limited English proficiency.

a. Translate pertinent state facility documents to major languages used by individuals accessing behavioral health and developmental services.
b. Develop a mechanism for central office and state facility staff to request document translation.
c. Offer Qualified Bilingual Staff Training.

Civil Commitment of Sexually Violent Predators

Virginia legislation creating a civil commitment program for sexually violent predators (SVP) mandates the Department to open and operate a civil commitment program for persons found to be sexually violent predators, as defined in §37.2-900. VCBR, a 300 bed facility located in Burkeville, provides individualized rehabilitation in a secure environment. Sexually violent predators are convicted sex offenders who are civilly committed to the Department at the end of their confinement in the Department of Corrections because of their histories of habitual sexually violent behavior and because their ability to control their violent tendencies is compromised by the presence of a mental abnormality or personality disorder. These individuals are predominantly male and are on average about 40 years old. They have long histories of sexually abusing children and adults and have shown very limited ability or willingness to abstain from committing sexual offenses.

International experience with the SVP population supports the use of a rehabilitation approach based on cognitive-behavioral principles and focused on relapse prevention. Rehabilitation involves multiple, daily group sessions, individual behavioral therapy, vocational training, and work therapy and programs, as appropriate. Security and direct care staff work with clinicians to create an environment that challenges deviant and criminal thinking and behavior while reinforcing appropriate behavior.

VCBR was originally designed and funded to reflect a system based on four SVP predicate crimes, with a projected commitment rate of about two individuals per month. However, 2006 Code changes increased the number of predicate crimes from 4 to 28 and changed the screening tool, which increased the numbers who are eligible for SVP commitment. VCBR reached its 200 bed operating capacity in June 2010 and its census is projected to grow from 356 in FY 2012 to 738 in FY 2017. No new beds are scheduled to be built. The General Assembly has directed the Department to implement a plan to double bunk up to150 additional VCBR residents in the current facility and has directed JLARC to study the full SVP process and report its findings and recommendations by November 30, 2011. A number of changes are

needed in the program to solve the overcrowding problem, including reducing the number and types of admissions and safely placing eligible individuals on conditional release.

Goal, Objective, and Implementation Action Steps

Goal: Address SVP service capacity issues in order to appropriately access and safely operate the Virginia Center for Behavioral Rehabilitation and provide SVP rehabilitation services.

Objective and Implementation Action Steps:

1. Meet the needs for additional bed and treatment space at VCBR.

a. Reconfigure treatment, medical, education, food services, and security to serve up to 150 additional individuals at VCBR.

b. Support VCBR in facilitating safe and appropriate conditional release of eligible residents.

State Facility Capital Infrastructure and Energy Efficiencies

State facilities operated by the Department include 408 buildings containing about 6 million square feet of space on 12 campuses. Building age averages 49 years, with a median age of 55 years. Inadequate maintenance and renovation funding has left many buildings in generally poor condition, requiring major building systems replacements such as fire alarm and fire sprinkler systems, renovations for appropriate emergency egress, hurricane hardening, and increased numbers of bathrooms. Many buildings also are inefficient to operate and require major renovations to meet current life safety standards and certification requirements.

The Department's proposed Six Year Capital Improvement Plan (2012-2018) has two essential components. The first is projects necessary to keep operational buildings in use for the next three biennia, including roof, utility, HVAC, and environmental hazard abatement. The second is a phased program of facility replacements to improve physical environments and appropriately address the program needs of individuals receiving services (see Appendix G).

Recently completed projects at ESH removed 11 outdated buildings that were beyond their useful life. Three other buildings of the same vintage were vacated but remain on the campus. Two new structures, the adult mental health treatment center and the Hancock Geriatric Treatment Center, are now occupied. A final phase to consolidate the remaining support services into a single building is part of the Six-Year Capital Improvement Plan.

SEVTC is undergoing a major capital improvement project that will replace 20 cottages constructed in the 1970s with 15 new 5-bedroom homes on the campus. This project is scheduled to be completed and occupied in early 2012. In parallel with this project, the Department is constructing six waiver homes and seven intermediate care facilities in the community to serve many individuals who are currently being served at SEVTC. This effort is being undertaken jointly with local CSBs that are contributing to the construction of the intermediate care facilities.

The Department has initiated major projects at CVTC. Two residential buildings are currently under construction. Two additional buildings are currently under design for renovation and an additional building is in the planning stage for its renovation. Planning and design is underway to provide six buildings with life safety improvements that will allow the campus to vacate several buildings that would not meet current code requirements.

The construction of the replacement of WSH has begun and is scheduled for completion in early 2013. This work is being accomplished utilizing a Public-Private Education and Infrastructure Act process that employs design-build principles to expedite completion. The new 246-bed facility is designed to be on the leading edge of mental health treatment facilities.

According to the most recent Department of Mines, Minerals and Energy report, the Department accounted for nearly 30 percent of all reported energy cost savings statewide, making it a leader among state agencies, including colleges and universities. Of the non-education related departments reporting, the Department accounted for more than 75 percent of all energy savings reported in the Commonwealth. The Department has implemented a computerized maintenance management system that tracks energy consumption at each facility and continues to explore strategies to reduce state facility energy consumption, increase efficiency, and reduce costs, including:

- ***Energy Performance Contract:*** The Department is modernizing aging state facility energy delivery systems and has reduced energy consumption and operating costs through successful emergency performance contracts at the Petersburg Complex (SVTC, Hiram HDMC and CSH), SWVMHI, CVTC, SWVTC, and CH.
- ***Renewable Energy Sources:*** SWVTC has converted its residential buildings to ground-source heat pumps; a system that uses the earth as an energy storage mechanism and is far more efficient in extreme temperatures. PGH now has the flexibility to burn several low-cost fuels such as warm season grasses in its biomass boiler. This past winter PGH burned these grasses when it would normally have switched to oil, significantly mitigating its carbon footprint and saving nearly $250,000.
- ***Laundry Energy Improvements:*** The Department has consolidated PGH and VCBR laundry functions at SVTC and is processing another facility's laundry through the Virginia Correctional Enterprise system.
- ***Building Area Reductions:*** The new ESH has reduced the facility's building area by nearly 50 percent and achieved greater energy efficiency. CVTC has taken several buildings off its energy system, reducing operating costs and energy consumption. The new WSH will have the same bed capacity but with its smaller building area and a design that meets the U.S. Green Building Council's LEED® criteria for SILVER, operating and energy costs should be reduced significantly.

In accordance with the Governor's request to further reduce energy consumption, the Department has identified several potential energy savings projects, including changes to CVTC's central boiler plant size to better match the load served by introducing smaller, high-efficiency boilers located nearer the load served to eliminate distribution system losses.

Goal, Objective, and Implementation Action Steps

Goal: Provide state facility infrastructure that efficiently and appropriately meets the needs of individuals receiving services.

Objective and Implementation Action Steps:

1. Improve the capital infrastructure of state hospitals and training centers to assure their compliance with life safety and applicable building codes and their appropriateness for active treatment services and supports.

a. Continue to update state facility master plans to appropriately address the programming needs of individuals receiving services.

b. Complete state facility replacements and major renovations.

c. Continue to work with state facilities to identify and implement initiatives that generate energy efficiencies.

d. Implement state facility projects necessary to keep operational buildings in use, including roof, utility, HVAC, and environmental hazard abatement.

VIII. RESOURCE REQUIREMENTS

The following capacity development priorities respond to critical issues facing Virginia's behavioral health and developmental services system. Implementation of these capacity development priorities is contingent on resource availability.

Behavioral Health Services Investment Priorities

- Expand statewide capacity and fill identified gaps in emergency and crisis response services and expand services that prevent or reduce the need for crisis response services. Based on a statewide assessment, these services include local purchase of inpatient psychiatric services, Programs of Assertive Community Treatment (PACT), police reception and drop-off program, emergency critical time intervention services, and Crisis Intervention Teams (CITs).
- Enhance state hospital effectiveness and efficiencies by decreasing forensic pressures on state hospitals with expanded funds for Discharge Assistance Project (DAP) placements, outpatient restoration services, and outpatient forensic evaluations; enhancing Southern Virginia Mental Health Institute forensic capacity; and addressing capacity issues at Northern Virginia Mental Health Institute and Commonwealth Center for Children and Adolescents.
- Expand statewide capacity and fill identified gaps in substance abuse treatment services and implement a substance abuse services workforce development initiative. Based on a statewide assessment, these services include case management, community diversion services for young non-violent offenders, intensive outpatient services, detoxification services, adolescent services, medication assisted treatment, residential services for pregnant women and women with dependent children in Southwest Virginia, intensive coordinated care for pregnant and post-partum women (Project Link), peer support services, employment services, supportive living capability, and uniform screening and assessment for substance use disorders.
- Expand child and adolescent behavioral health services statewide to fill identified gaps in basic services, improve quality management and oversight, and implement a children's behavioral health workforce initiative. Based on a statewide assessment, these base services include regional crisis stabilization units and mobile crisis response teams for children, case management, and psychiatric services.
- Establish an Office of Peer Services and Recovery Supports to facilitate development of peer services and recovery supports and assure that peer support specialists demonstrate that they meet competency requirements through a state certification program.

Developmental Services Investment Priorities

- Collaborate with the Department of Medical Assistance Services (DMAS) to expand waiver capacity, modify existing or create new waivers, and address waiver rate structures.
- Expand developmental services capacity to implement the settlement agreement with the U.S. Department of Justice (DOJ).
- Improve the Department's quality assurance and oversight capacity to identify deficiencies, allow electronic individual-level tracking of incidents and systemic analyses of trends and patterns, and follow-up to assure corrective action plans are implemented.

Systemwide Investment Priorities

- Establish a state certification program with core competency training for case managers to demonstrate that they meet competency and training requirements.
- Implement the clinical treatment/medical records modules of an electronic health record (EHR) at all the state facilities.
- Improve Department quality assurance and improvement processes.

IX. CONCLUSION

This document responds to the requirement in §37.2-315 of the *Code of Virginia* for a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services that identifies the services and supports needs of individuals receiving behavioral health and developmental services in Virginia and proposes objectives and action steps to address these needs.

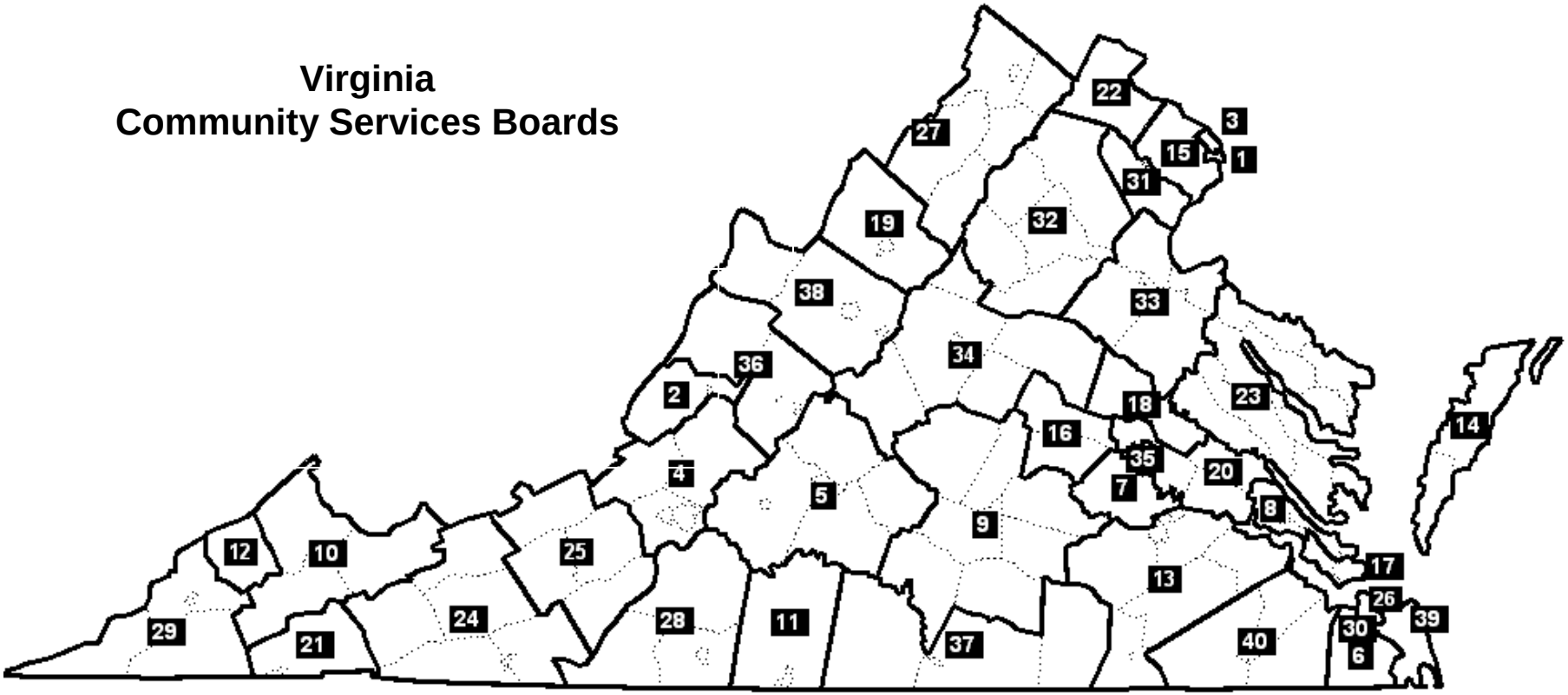
The policy agenda for the publicly funded behavioral health and developmental services system for the next biennium will focus on sustaining progress in implementing the vision of recovery and person-centered delivery of behavioral health and developmental services and investing in the services capacity and infrastructure needed to address issues facing the services system.

The Department's executive leadership will continue to monitor implementation of the Creating Opportunities strategic initiatives and major agency activities identified in the *Comprehensive State Plan 2012-2018*. Successful implementation of these strategic initiatives will continue Virginia's progress in advancing a community-focused system of recovery-oriented and person-centered services and supports that promote the highest possible level of participation by individuals receiving behavioral health or developmental services in all aspects of community life including work, school, family, and other meaningful relationships.

Implementation of the plan's initiatives also will support the Governor's expressed intention to achieve a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services. They also will enhance the ability of the services system to perform its core functions in a manner that is effective, efficient, and responsive to the needs of individuals receiving services and their families.

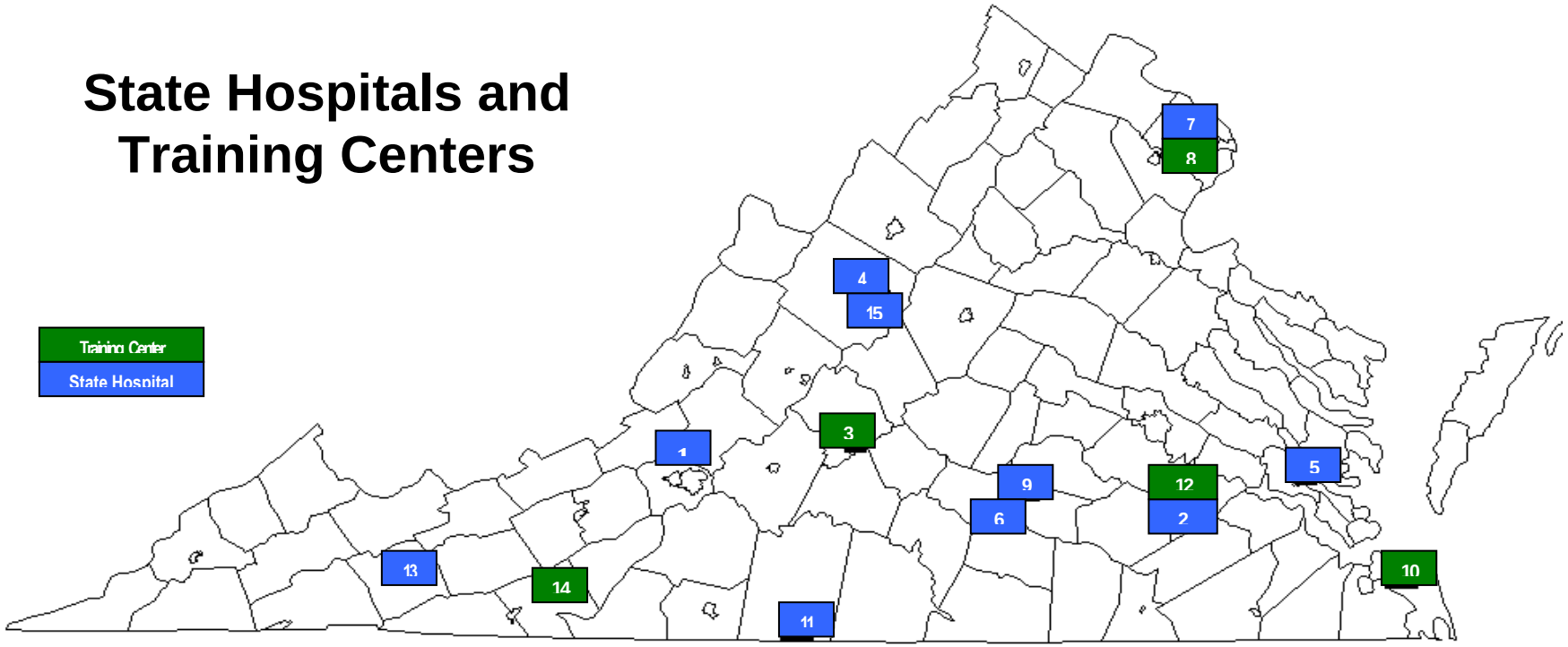
Appendix A

Maps of Community Services Board Service Areas and State Mental Health and Mental Retardation Facility Locations



1	Alexandria	11	Danville-Pittsylvania	21	Highlands	31	Prince William
2	Alleghany Highlands	12	Dickenson	22	Loudoun	32	Rappahannock-Rapidan
3	Arlington	13	District 19	23	Mid Peninsula-Northern Neck	33	Rappahannock Area
4	Blue Ridge	14	Eastern Shore	24	Mount Rogers	34	Region Ten
5	Central Virginia	15	Fairfax-Falls Church	25	New River Valley	35	Richmond
6	Chesapeake	16	Goochland-Powhatan	26	Norfolk	36	Rockbridge Area
7	Chesterfield	17	Hampton-Newport News	27	Northwestern	37	Southside
8	Colonial	18	Hanover	28	Piedmont	38	Valley
9	Crossroads	19	Harrisonburg-Rockingham	29	Planning District 1	39	Virginia Beach
10	Cumberland Mountain	20	Henrico Area	30	Portsmouth	40	Western Tidewater

State Hospitals and Training Centers



	Facility	Location		Facility	Location
1	Catawba Hospital	Catawba	9	Piedmont Geriatric Hospital	Burkeville
2	Central State Hospital	Petersburg	10	Southeastern VA Training Center	Chesapeake
3	Central VA Training Center	Madison Heights	11	Southern VA MH Institute	Danville
4	CCCA	Staunton	12	Southside VA Training Center	Petersburg
5	Eastern State Hospital	Williamsburg	13	Southwestern VA MH Institute	Marion
6	Behavioral Rehabilitation Center	Burkeville	14	Southwestern VA Training Center	Hillsville
7	Northern VA MH Institute	Falls Church	15	Western State Hospital	Staunton
8	Northern VA Training Center	Fairfax			

Appendix B
Descriptions of Populations Served

Individuals Who Have a Serious Mental Illness or Serious Emotional Disturbance

A mental disorder is broadly defined in the *DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision)* as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment of one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Serious Mental Illness means a severe and persistent mental or emotional disorder that seriously impairs the functioning of adults, 18 years of age or older, in such primary aspects of daily living as personal relationships, self-care skills, living arrangements, or employment. Individuals with serious mental illness who also have been diagnosed as having a substance use disorder or intellectual disability are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

- *Diagnosis:* an individual must have a major mental disorder diagnosed under the *DSM-IV-TR*. These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability.
- *Level of Disability:* There must be evidence of severe and recurrent disability resulting from mental illness that must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis.
    a. Is unemployed or employed in a sheltered setting or a supportive work situation, has markedly limited or reduced employment skills, or has a poor employment history.
    b. Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
    c. Has difficulty establishing or maintaining a personal social support system.
    d. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
    e. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
- *Duration of Illness:* The individual is expected to require services of an extended duration, or his treatment history meets at least one of the following criteria.
    a. The individual has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.
    b. The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Substance use disorders frequently occur in conjunction with serious mental illness.

Serious Emotional Disturbance means a serious mental health problem that affects a child, from birth through age17, and can be diagnosed under *DSM-IV-TR* or meets specific functional criteria.

- Problems in personality development and social functioning that have been exhibited over at least one year's time,
- Problems that are significantly disabling based on social functioning of most children of the child's age,
- Problems that have become more disabling over time, and

- Service needs that require significant intervention by more than one agency.

Substance use disorders frequently occur in conjunction with serious emotional disturbance.

Children "At-Risk" of Serious Emotional Disturbance means a condition experienced by a child, from birth through age 7, which meets at least one of the following criteria:

- The child exhibits behavior or maturity is significantly different from most children of the child's age, and is not due to developmental or intellectual disability, or
- Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorders, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavior problems, or
- The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, which put him at risk for serious emotional or behavior problems.

Individuals Who Have Intellectual or Other Developmental Disability

Intellectual disability means a disability originating before the age of 18 years that is characterized concurrently by (i) significantly sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. With each individual, limitations often co-exist with strengths. Intellectual disability is a life-long disability; however, with appropriate personalized supports over a sustained period, the life functioning of individuals generally will improve.

Developmental disabilities are a diverse group of severe chronic conditions that are due to mental or physical impairment, or both, are manifested before a person reaches age 22, and usually last throughout a person's lifetime. People with developmental disabilities may have problems with major life activities such as language, mobility, learning, self-help, and independent living. Among the array of developmental disability conditions, the Department and CSBs may serve individuals who have an autism spectrum disorder or a severe chronic disability that is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, that is found to be closely related to intellectual disability when the condition results in substantial functional limitations in three or more areas of major life activities and impairment of general intellectual functioning or adaptive behavior that is similar to that of persons with intellectual disability and requires comparable services or supports.

Individuals Who Have a Substance Use Disorder

According to the Diagnostic and Statistical Manual (DSM IV-TR), substance use disorders (SUDs) are types of mental disorders that are "related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure." There are two levels of substance use disorders: substance dependence and substance abuse. The DSM-IV-TR provides criteria for each level.

- Criteria for a diagnosis of substance dependence focuses "impairment or distress… manifested by three (or more) [symptoms] in a twelve month period" to include:
    1. Tolerance (needing more of the substance to achieve the desired level of intoxication or effect, or experiencing a diminished effect using the same amount of the substance);
    2. Withdrawal (marked by a physical syndrome related to the specific substance, or taking the substance to avoid withdrawal symptoms);
    3. Taking larger amounts or taking the substance over longer periods than intended (e.g., not being able to limit the number of alcoholic beverages consumed at a given event);
    4. Persistent desire combined with unsuccessful efforts to reduce use of the substance;
    5. Expending large amounts of time obtaining the substance use the substance or recover from its effects, to the point where the individual's life becomes focused on the substance;

6. Engagement in important social, occupational or recreational activities are reduced due to substance use; and
7. Continued use despite knowledge that the substance use is causing a persistent physical or psychological problem (e.g., persistent drinking in spite of knowing that an ulcer is made worse by alcohol consumption).

- Criteria for substance abuse focuses on “a maladaptive pattern of substance use leading to clinically significant impairment or distress,” indicated by at least one of the following within a twelve month period:
  1. Failure to fulfill major role obligations at work, school or home (e.g., repeated absences at work related to substance use; expulsion from school; neglect of children or household duties);
  2. Recurrent use of the substance in situations which are physically hazardous (e.g., driving while intoxicated);
  3. Recurrent arrests related to substance use (e.g., arrests for disorderly conduct after consuming alcohol); and
  4. Continued use of the substance despite persistent or recurrent social problems related to use of the substance (e.g., physical fights while intoxicated; arguing with significant others about the consequences of intoxication).

An individual’s symptoms related to a specific substance can never have met the criteria for substance dependence.

Appendix C
Community Services Board Services Utilization

Community services boards (CSBs) offer varying combinations of core services, directly and through contracts with other organizations. All tables show actual data, derived from annual community services performance contract reports and community consumer submission extracts submitted by CSBs. Trends in numbers of individuals served between state FY 1988 and FY 2008, using the revised Taxonomy that created an additional category for services – Services Available Outside of a Program Area follow.

Table 1: Individuals Served by CSBs[1]

FY	Mental Health Services		Developmental Services		Substance Abuse Services		Services Available Outside of a Program Area		Total	
	Und.[2]	Dupl.[3]	Und.[2]	Dupl.[3]	Und.[2]	Dupl.[3]	Und.[2]	Dupl.[3]	Und.[2]	Dupl.[3]
1988	110,082	161,033	14,354	22,828	57,363	80,138			181,799	263,999
1989	107,892	157,825	17,361	27,610	62,905	87,878			188,158	273,313
1990	NA	152,811	NA	30,198	NA	101,816			NA	284,825
1991	NA	161,536	NA	28,539	NA	103,288			NA	293,363
1992	NA	160,115	NA	27,525	NA	78,358			NA	265,998
1993	105,389	158,115	19,010	27,696	55,871	80,271			180,270	266,082
1994	107,131	168,208	19,742	28,680	59,471	87,166			186,344	284,054
1995	106,637	177,320	18,572	29,141	61,463	88,471			186,672	294,932
1996	116,344	174,126	19,169	30,006	64,309	90,750			199,822	294,882
1997	115,169	179,500	20,557	30,655	63,040	90,099			198,766	300,254
1998	119,438	185,647	20,983	32,509	68,559	96,556			208,980	314,712
1999	112,729	178,334	21,772	33,087	64,899	93,436			199,400	304,857
2000	118,210	180,783	22,036	26,086	61,361	88,358			201,607	295,227
2001	105,169	178,254	23,843	33,238	59,968	102,037			188,980	313,529
2002	107,351	176,735	24,903	33,933	59,895	91,904			192,149	302,572
2003	109,025	180,110	25,207	34,103	57,526	86,979			191,758	301,102
2004	109,175	181,396	23,925	35,038	53,854	78,008			186,954	294,442
2005	115,173	188,289	26,050	39,414	53,909	76,141			195,132	303,844
2006	118,732	195,794	26,893	36,004	52,416	73,633			198,041	305,431
2007	126,632	207,454	27,619	36,573	53,905	73,829			208,156	317,856
2008	101,796	161,046	25,053	36,141	43,657	57,219	73,123	85,896	243,629	340,302
2009	104,831	165,066	27,172	35,350	40,723	52,104	80,225	91,452	252,951	343,972
2010	108,158	171,506	19,374	25,909	38,661	51,204	85,158	103,041	251,351	351,660
2011	107,892	174,183	20,387	26,912	36,769	48,964	86,881	97,776	251,929	353,814

NOTES:

1 Unduplicated counts of individuals were not collected by the Department every year. The NA notations show years in which this information was not collected.

2 Unduplicated (**Und.**) numbers of individuals are the total number of individuals receiving services in a program (mental health, developmental, or substance abuse services) area, regardless of how many services they received. If an individual with a dual diagnosis (e.g., mental illness and substance use disorder) received services in both program areas, he would be counted twice.

3 Duplicated (**Dupl.**) numbers of individuals are the total numbers of individuals receiving each category or subcategory of core services. Thus, if an individual received outpatient, rehabilitation, and supervised residential services, he would be counted three times, since he received three core services. These totals are added to calculate a total number of individuals served for each program area.

With the implementation in FY 2004 of the Community Consumer Submission (software that extracts data on each individual receiving services from CSB information systems and transmits encrypted data to the Department) a totally unduplicated count of individuals at the CSB level across all program areas was available. The difference between the total unduplicated figure and the sum of the unduplicated number of individuals in each program area, shown in the preceding table, gives some indication of the numbers of individuals who may be receiving services in more than one program area. For example, in FY 2010, 56,689 individuals received services in more than one program area

Table 2: Unduplicated Count of Individuals Receiving CSB Services

FY	Number of Individuals
2004	167,096
2005	174,183
2006	176,276
2007	185,287
2008	190,125
2009	198,271
2010	194,662
2011	196,951

Table 3: FY 2011 Community Services Board Static Capacities by Core Service

Services Available at Admission to a Program Area	MH Services	DV Services	SA Services	Grand TOTAL
Adult Psychiatric or Substance Abuse Inpatient	43.67		2.08	45.75
Community-Based SA Medical Detox Inpatient			5.08	5.08
Total Local Inpatient Services Beds	43.67		7.16	43.67
Day Treatment/Partial Hospitalization	2,673.53		159.08	2832.61
Ambulatory Crisis Stabilization Services	50.96			50.96
Rehabilitation/Habilitation	2,757.02	1,986.15		4743.17
Sheltered Employment	41.3	701.05		586.29
Transitional/Supported Employment	17.77	88.6		106.37
Group Supported Employment	11	544.99		555.99
Total Day Support Services Slots	5,533.81	3,232.19	159.08	8,769.02
Highly Intensive Residential Services	56.92	157.38	107.91	322.21
Residential Crisis Stabilization Services	133.93		6.49	140.42
Intensive Residential Services	181.56	782.93	715.71	1680.2
Supervised Residential Services	694.3	448.26	102.93	1245.49
Supportive Residential Services	611.79	428.21	6.6	1046.6
Total Residential Services Beds	**1,066.71**	**1,388.57**	**933.04**	**3,388.32**

Note: Decimal fractions of beds and slots result from calculating these capacities for contracted services where a CSB purchases a number of bed days or days of service, which must be converted to numbers of beds or day support slots.

Table 4: FY 2011 Unduplicated Numbers of Individuals Receiving CSB Services by Age and Gender													
Age	MH Services			DV Services			SA Services			Services Available Outside Program Area			Total
	Fem.	Male	Unk	Fem.	Male	Unk	Fem.	Male	Unk	Fem.	Male	Unk	
0-2	371	533	2	740	1,248		43	49		108	173	5	3,038
3-12	6,808	12,201	22	817	1,428	1	63	172		2,669	4,136	41	20,610
13-17	5,755	7,040	9	554	843	1	945	2,474	1	5,073	7,165	56	23,277
18-22	3,660	3,672	10	978	1,466	3	1,692	3,278		4,379	6,013	65	19,088
23-59	32,666	27,773	4	4,985	6,124	1	10,172	17,272	18	23,948	27,205	217	116,873
60-64	2,151	1,290	2	269	302		10	277		1,010	903	4	5,833
65-74	1,860	973		244	236		38	118		1,146	834	15	5,233
75+	725	284	1	76	65		5	10		920	653	19	2,806
Unknown	16	19	2		4	2	8	26	1	59	46	19	193
Total	**54,012**	**53,785**	**95**	**8,663**	**11,716**	**8**	**13,069**	**23,676**	**24**	**39,312**	**47,128**	**441**	**196,951**

Table 5: FY 2011 Numbers of Individuals Served Receiving CSB Services by Race					
Race	MH Services	DV Services	SA Services	Services Available Outside of a Program Area	Total
Alaskan	50	18	20	35	97
American Indian	245	30	98	169	419
Black or African American	30,866	6,534	11,205	23,749	56,375
White	67,295	12,075	22,199	51,770	119,596
Other	4,368	651	1,920	5,145	9,259
Asian	1,105	393	254	1,273	2,403
Native Hawaiian or Other Pacific Islander	99	24	20	73	163
American Indian or Alaska Native and White	157	11	60	113	249
Asian and White	207	42	80	227	440
Black or African American and White	1,517	205	263	851	2,283
American Indian or Alaska Native and Black or African American	71	6	44	56	138
Other Multi-Race	955	152	278	626	1,594
Unknown/ Not Collected	957	246	328	2,794	3,935
Total	**107,892**	**20,387**	**36,769**	**86,881**	**196,951**

Appendix D
State Hospital and Training Center Utilization

Individuals Served in State Hospitals, Average Daily Census, Admissions, and Separations -- FY 2011

MH Facility	# Individuals Served	Average Daily Census	# Admissions	# Separations
Eastern State Hospital	410	289	102	147
Western State Hospital	717	227	557	558
Central State Hospital	671	232	483	492
Southwestern VA MHI	802	140	856	849
Northern VA MHI	836	115	873	878
Southern VA MHI	336	71	325	329
Commonwealth Center for Children and Adolescents	644	35	780	774
Catawba Hospital	341	100	322	323
Piedmont Geriatric Hospital	177	110	68	71
Total*	**4,779**	**1,319**	**4,366**	**4,421**

Individuals Served by Hiram Davis Medical Center, ADC, Admissions, and Separations -- FY2011

	# Individuals Served	Average Daily Census	# Admissions	# Separations
Hiram Davis Medical Center	126	58	77	76

Individuals Served by Virginia Center for Behavioral Rehabilitation, ADC, Admissions, & Separations -- FY2011

	# Individuals Served	Average Daily Census	# Admissions	# Separations
VCBR	295	239	80	21

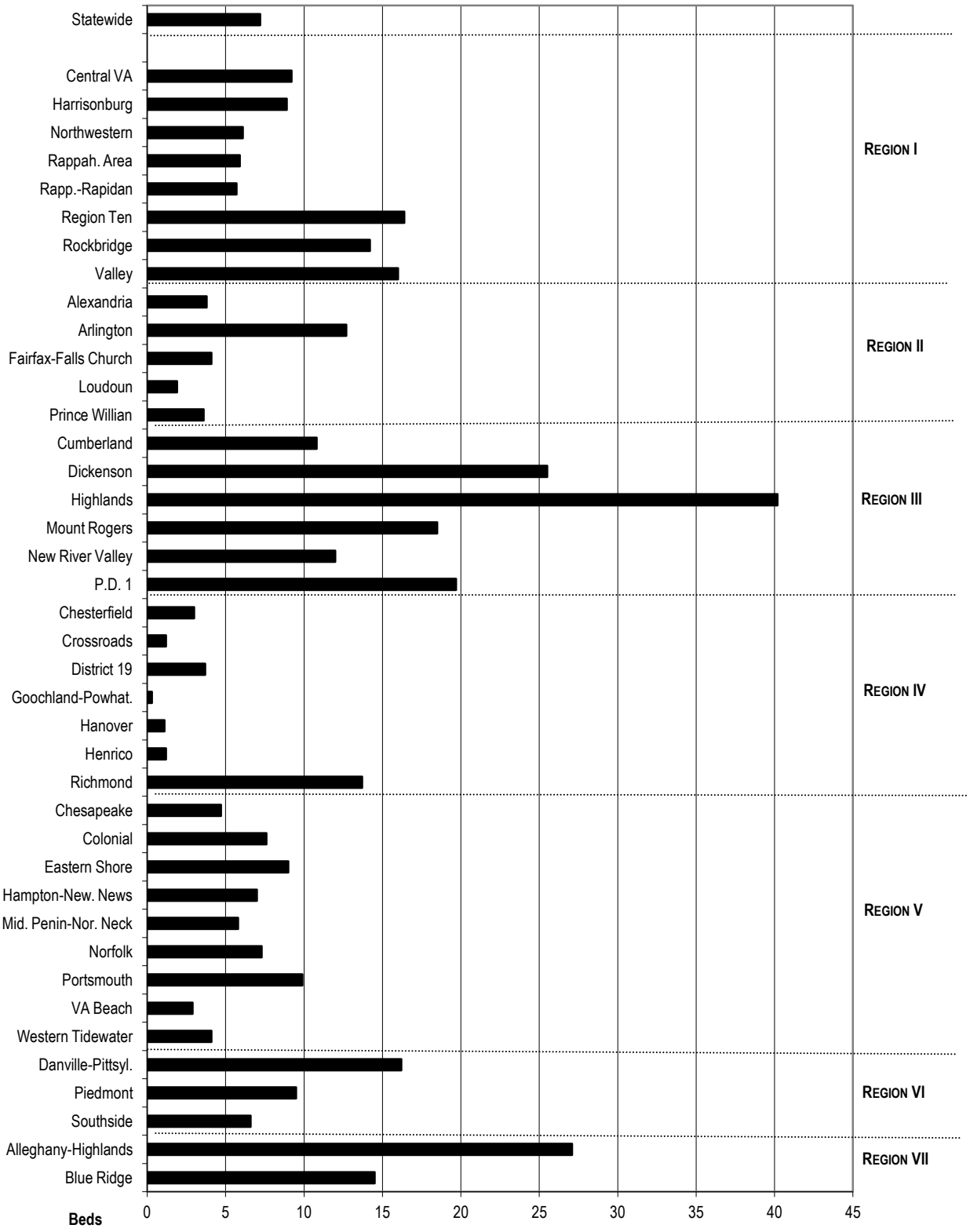
Individuals Served in Training Centers, ADC, Admissions, and Separations -- FY2011

Training Center	# Individuals Served	Average Daily Census	# Admissions	# Separations
Central Virginia TC	417	393	5	38
Northern Virginia TC	182	157	51	61
Southeastern Virginia TC	151	126	19	34
Southside Virginia TC	270	246	10	29
Southwestern Virginia TC	206	182	26	31
Total	**1,226**	**1,104**	**111**	**193**

Source: DBHDS AVATAR Information System
*Unduplicated count (unique individuals) by state facility type

TOTAL UNDUPLICATED COUNT OF INDIVIDUALS SERVED ACROSS ALL STATE FACILITIES: 6,338

Adult Civil State Hospital Bed Utilization by CSB and Region FY 2011
Beds per 100,000 Population

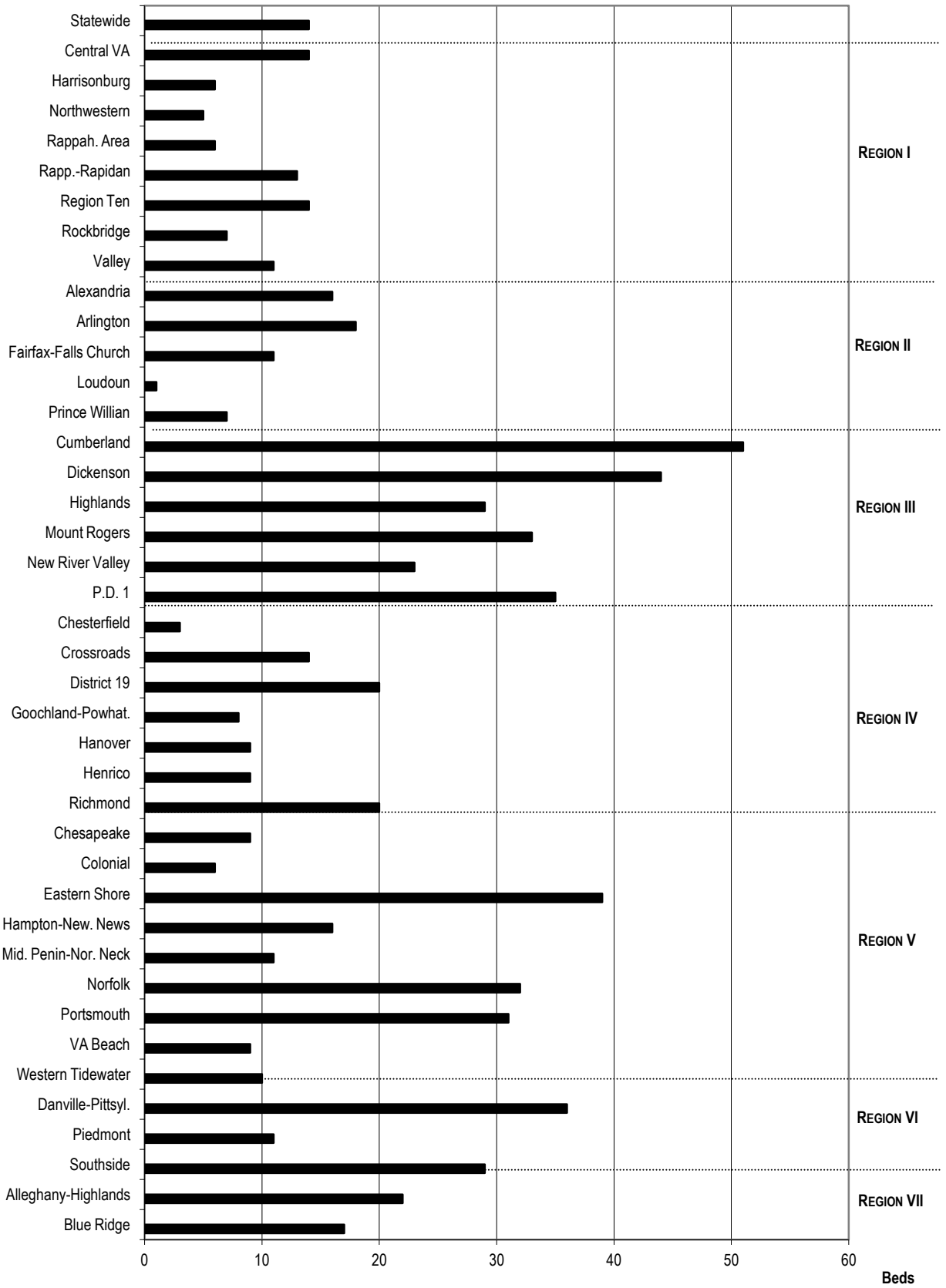


Adult Civil State Hospital Facility Utilization by CSB and Region -- FY2011

	CSB	All Bed Days FY 2011	CSB Population	FY 2011 Bed Days Per 100 K Population	FY 2011 Beds Per 100 K Population
I	Central Virginia	8,523	252,634	3,374	9.2
	Harrisonburg-Rockingham	4,055	125,228	3,238	8.9
	Northwestern	4,980	222,152	2,242	6.1
	Rappahannock Area	7,092	327,773	2,164	5.9
	Rappahannock-Rapidan	3,463	166,054	2,085	5.7
	Region Ten	14,016	234,712	5,972	16.4
	Rockbridge Area	2,117	40,730	5,198	14.2
	Valley	7,046	120,823	5,832	16.0
II	Alexandria	1,932	139,966	1,380	3.8
	Arlington	9,603	207,627	4,625	12.7
	Fairfax-Falls Church	16,544	1,116,623	1,482	4.1
	Loudoun County	2,208	312,311	707	1.9
	Prince William County	6,002	454,096	1,322	3.6
III	Cumberland Mountain	3,868	98,073	3,944	10.8
	Dickenson County	1,479	15,903	9,300	25.5
	Highlands	10,666	72,711	14,669	40.2
	Mount Rogers	8,175	120,884	6,763	18.5
	New River Valley	7,795	178,237	4,373	12.0
	Planning District 1	6,785	94,174	7,205	19.7
IV	Chesterfield	3,466	316,236	1,096	3.0
	Crossroads	459	104,609	439	1.2
	District 19	2,317	173,463	1,336	3.7
	Goochland-Powhatan	56	49,763	113	0.3
	Hanover County	411	99,863	412	1.1
	Henrico Area	1,403	332,620	422	1.2
	Richmond BHA	10,180	204,214	4,985	13.7
V	Chesapeake	3,781	222,209	1,702	4.7
	Colonial	4,374	158,691	2,756	7.6
	Eastern Shore	1,493	45,553	3,278	9.0
	Hampton-Newport News	8,088	318,155	2,542	7.0
	Middle Pen.-Northern Neck	2,991	141,255	2,117	5.8
	Norfolk	6,503	242,803	2,678	7.3
	Portsmouth	3,443	95,535	3,604	9.9
	Virginia Beach	4,575	437,994	1,045	2.9
	Western Tidewater	2,186	147,007	1,487	4.1
VI	Danville-Pittsylvania	6,314	106,561	5,925	16.2
	Piedmont	4,933	142,621	3,459	9.5
	Southside	2,094	86,402	2,424	6.6
VII	Alleghany Highlands	2,199	22,211	9,900	27.1
	Blue Ridge	13,386	252,548	5,300	14.5
	VIRGINIA STATEWIDE	**211,001**	**8,001,024**	**2,637**	7.2

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau
Note: Excludes HRMC, VCBR, and CCCA

Training Center Bed Utilization by CSB and Region FY 2011
Beds Per 100,000 Population



State Training Center Utilization by CSB and Region -- FY 2011

	CSB	All Bed Days FY 2011	CSB Population	FY 2011 Bed Days Per 100 K Population	FY 2011 Beds Per 100 K Population
I	Central Virginia	13,107	252,634	5,188	14.21
	Harrisonburg-Rockingham	2,573	125,228	2,055	5.63
	Northwestern	4,375	222,152	1,969	5.40
	Rappahannock Area	7,028	327,773	2,144	5.87
	Rappahannock-Rapidan	7,822	166,054	4,711	12.91
	Region Ten	11,576	234,712	4,932	13.51
	Rockbridge Area	1,095	40,730	2,688	7.37
	Valley	4,734	120,823	3,918	10.73
II	Alexandria	7,979	139,966	5,701	15.62
	Arlington	13,388	207,627	6,448	17.67
	Fairfax-Falls Church	45,515	1,116,623	4,076	11.17
	Loudoun County	1,120	312,311	359	0.98
	Prince William County	10,926	454,096	2,406	6.59
III	Cumberland Mountain	18,241	98,073	18,599	50.96
	Dickenson County	2,555	15,903	16,066	44.02
	Highlands	7,793	72,711	10,718	29.36
	Mount Rogers	14,408	120,884	11,919	32.65
	New River Valley	15,227	178,237	8,543	23.41
	Planning District 1	11,983	94,174	12,724	34.86
IV	Chesterfield	3,981	316,236	1,259	3.45
	Crossroads	5,396	104,609	5,158	14.13
	District 19	12,764	173,463	7,358	20.16
	Goochland-Powhatan	1,460	49,763	2,934	8.04
	Hanover County	3,390	99,863	3,395	9.30
	Henrico Area	11,091	332,620	3,334	9.14
	Richmond BHA	14,720	204,214	7,208	19.75
V	Chesapeake	7,008	222,209	3,154	8.64
	Colonial	3,615	158,691	2,278	6.24
	Eastern Shore	6,417	45,553	14,087	38.59
	Hampton-Newport News	18,392	318,155	5,781	15.84
	Middle Pen.-Northern Neck	5,913	141,255	4,186	11.47
	Norfolk	28,770	242,803	11,849	32.46
	Portsmouth	10,796	95,535	11,301	30.96
	Virginia Beach	14,722	437,994	3,361	9.21
	Western Tidewater	5,358	147,007	3,645	9.99
VI	Danville-Pittsylvania	13,937	106,561	13,079	35.83
	Piedmont	5,465	142,621	3,832	10.50
	Southside	8,990	86,402	10,405	28.51
VII	Alleghany Highlands	1,811	22,211	8,154	22.34
	Blue Ridge	16,029	252,548	6,347	17.39
Out of State/Unknown/Unassigned		2,155			
	VIRGINIA STATEWIDE	**403,625**	**8,001,024**	**5,045**	**13.82**

Source: DBHDS AVATAR and 2010 Census counts, US Census Bureau

FY 2011 Numbers Served by Age and Gender

Age	State Hospitals		Training Centers		Hiram Davis		VCBR		Unduplicated TOTAL		
	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Fem.	Male	Total
0-17	255	384	2	3	0	0	0	0	258	390	**648**
18-22	114	275	5	19	3	1	0	2	118	292	**410**
23-59	1,086	1,924	376	574	37	51	0	274	1,476	2,777	**4,253**
60-64	95	117	50	65	2	7	0	11	148	196	**344**
65-74	162	163	47	45	6	3	0	7	213	214	**427**
75+	110	94	20	20	7	9	0	1	135	121	**256**
Total	**1,822**	**2,957**	**500**	**726**	**55**	**71**	0	**295**	**2,348**	**3,990**	**6,338**

FY 2011 Numbers Served by Race and Age

Race	State Hospitals				Training Centers			
	0-17	18-64	65+	Total	0-17	18-64	65+	Total
Alaskan Native	0	2	0	2	0	0	0	0
American Indian	2	5	1	8	0	1	0	1
Asian/Pacific Islander	3	78	6	87	0	7	0	7
Black/African American	202	1,271	161	1,634	0	276	26	302
Caucasian/White	390	2,135	359	2,884	3	783	106	892
Other	34	115	2	151	1	10	0	11
Not Collected/No Entry Unknown	8	5	0	13	1	12	0	13
Total	**639**	**3,611**	**529**	**4779**	**5**	**1,089**	**132**	**1,226**

Race	Hiram Davis			VCBR			Unduplicated TOTAL			
	18-64	65+	Total	18-64	65+	Total	0-17	18-64	65+	Total
Alaskan Native	0	0	0	0	0	0	0	2	0	**2**
American Indian	0	0	0	0	0	1	2	7	1	**10**
Asian/Pacific Islander	1	0	1	0	0	0	3	84	6	**93**
Black/African American	54	16	70	153	1	154	205	1,719	197	**2,121**
Caucasian/White	45	9	54	130	7	137	394	3,052	476	**3,922**
Other	1	0	1	2	0	2	35	125	3	**163**
Not Collected/No Entry Unknown	0	0	0	1	0	0	9	18	0	**27**
Total	**101**	**25**	**126**	**287**	**8**	**295**	**648**	**5,007**	**683**	**6,338**

Source: DBHDS AVATAR Information System

State Hospital and Training Center Numbers of Admissions, Separations, and Average Daily Census FY 1976 to FY 2011

	State Hospitals*			Training Centers**		
	Number of Admissions	Number of Separations	Average Daily Census	Number of Admissions	Number of Separations	Average Daily Census
FY 1976	10,319	10,943	5,967	250	639	4,293
FY 1977	10,051	10,895	5,489	418	618	3,893
FY 1978	10,641	11,083	5,218	277	404	3,790
FY 1979	10,756	10,926	5,112	299	416	3,701
FY 1980	10,513	11,345	4,835	296	428	3,576
FY 1981	10,680	11,513	4,486	252	399	3,467
FY 1982	10,212	10,616	4,165	205	301	3,391
FY 1983	10,030	10,273	3,798	162	232	3,309
FY 1984	9,853	10,163	3,576	194	322	3,189
FY 1985	9,456	9,768	3,279	197	314	3,069
FY 1986	8,942	9,077	3,110	172	280	2,970
FY 1987	8,919	8,900	3,004	165	238	2,892
FY 1988	9,549	9,637	3,047	143	224	2,828
FY 1989	9,591	9,605	3,072	146	231	2,761
FY 1990	9,249	9,293	2,956	110	181	2,676
FY 1991	9,323	9,519	2,904	107	162	2,626
FY 1992	9,057	9,245	2,775	116	215	2,548
FY 1993	8,560	8,651	2,588	94	192	2,481
FY 1994	9,187	9,317	2,482	106	193	2,375
FY 1995	8,550	8,774	2,348	87	216	2,249
FY 1996	7,468	7,529	2,222	87	223	2,132
FY 1997	7,195	7,257	2,118	77	210	1,987
FY 1998	7,431	7,522	2,089	78	170	1,890
FY 1999	6,210	6,449	1,914	106	188	1,812
FY 2000	5,069	5,233	1,694	101	194	1,749
FY 2001	5,223	5,176	1,641	101	156	1,680
FY 2002	5,936	5,915	1,654	122	177	1,618
FY 2003	5,946	6,008	1,609	95	132	1,581
FY 2004	5,382	5,599	1,588	73	114	1,568
FY 2005	5,232	5,236	1,478	114	174	1,524
FY 2006	5,334	5,293	1,490	112	188	1,451
FY 2007	5,146	5,149	1,511	128	182	1,389
FY 2008	4,960	5,025	1,501	134	196	1,328
FY 2009	4,884	5,042	1,419	111	179	1,275
FY 2010	4,809	4,856	1,355	100	194	1,196
FY 2011	4,366	4,421	1,319	111	193	1,104

* Excludes Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation. State Mental Health Facilities counts include the Virginia Treatment Center for Children (VTCC) through FY 1991 when the VTCC was transferred to MCV.

** Operations at SVTC began in 1971, NVTC began in 1973, SWVTC in 1973, and SEVTC began in 1975.

Appendix E
Prevalence Estimates by CSB

Estimated Prevalence of Serious Mental Illness by CSB and Region

	CSB	Population Age18+ (2010 Population)	Est. Population with SMI (3.9 %)	Lower Limit of SMI 95% Confidence Interval (3%)	Upper Limit of SMI 95% Confidence Interval (5%)
I	Central Virginia	198,968	7,760	5,969	9,948
	Harrisonburg-Rockingham	99,808	3,893	2,994	4,990
	Northwestern	169,933	6,627	5,098	8,497
	Rappahannock Area	238,370	9,296	7,151	11,919
	Rappahannock-Rapidan	125,427	4,892	3,763	6,271
	Region Ten	186,214	7,262	5,586	9,311
	Rockbridge Area	33,524	1,307	1,006	1,676
	Valley	95,211	3,713	2,856	4,761
II	Alexandria	115,996	4,524	3,480	5,800
	Arlington	175,001	6,825	5,250	8,750
	Fairfax-Falls Church	846,336	33,007	25,390	42,317
	Loudoun County	216,877	8,458	6,506	10,844
	Prince William County	323,115	12,601	9,693	16,156
III	Cumberland Mountain	78,480	3,061	2,354	3,924
	Dickenson County	12,580	491	377	629
	Highlands	58,250	2,272	1,748	2,913
	Mount Rogers	96,125	3,749	2,884	4,806
	New River Valley	147,084	5,736	4,413	7,354
	Planning District 1	75,051	2,927	2,252	3,753
IV	Chesterfield	233,721	9,115	7,012	11,686
	Crossroads	83,488	3,256	2,505	4,174
	District 19	135,716	5,293	4,071	6,786
	Goochland-Powhatan	38,886	1,517	1,167	1,944
	Hanover County	74,865	2,920	2,246	3,743
	Henrico Area	252,846	9,861	7,585	12,642
	Richmond BHA	166,205	6,482	4,986	8,310
V	Chesapeake	164,688	6,423	4,941	8,234
	Colonial	122,657	4,784	3,680	6,133
	Eastern Shore	36,192	1,411	1,086	1,810
	Hampton-Newport News	242,968	9,476	7,289	12,148
	Middle Peninsula-Northern Neck	112,956	4,405	3,389	5,648
	Norfolk	192,191	7,495	5,766	9,610
	Portsmouth	72,869	2,842	2,186	3,643
	Virginia Beach	332,745	12,977	9,982	16,637
	Western Tidewater	110,875	4,324	3,326	5,544
VI	Danville-Pittsylvania	83,814	3,269	2,514	4,191
	Piedmont	113,315	4,419	3,399	5,666
	Southside	68,676	2,678	2,060	3,434
VII	Alleghany Highlands	17,494	682	525	875
	Blue Ridge	197,830	7,715	5,935	9,892
	TOTAL	**6,147,347**	**239,747**	**184,420**	**307,367**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau
Methodology Source: 2008 and 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs) and publication NSDUH_078.

Estimated Prevalence of Child/Adolescent Serious Emotional Disturbance by CSB and Region

CSB		Population Age 9 through 17 (2010 Estimate)	Est. SED, Level of Functioning Score = 50		Est. SED, Level of Functioning Score = 60	
			Lower	Upper	Lower	Upper
I	Central Virginia	30,407	1,520	2,128	2,737	3,345
	Harrisonburg-Rockingham	16,341	817	1,144	1,471	1,798
	Northwestern	26,726	1,336	1,871	2,405	2,940
	Rappahannock Area	46,467	2,323	3,253	4,182	5,111
	Rappahannock-Rapidan	20,824	1,041	1,458	1,874	2,291
	Region Ten	26,258	1,313	1,838	2,363	2,888
	Rockbridge Area	4,541	227	318	409	499
	Valley	13,190	660	923	1,187	1,451
II	Alexandria	8,873	444	621	799	976
	Arlington	13,327	666	933	1,199	1,466
	Fairfax-Falls Church	131,125	6,556	9,179	11,801	14,424
	Loudoun County	42,612	2,131	2,983	3,835	4,687
	Prince William County	62,007	3,100	4,340	5,581	6,821
III	Cumberland Mountain	10,290	514	720	926	1,132
	Dickenson County	1,728	86	121	156	190
	Highlands	7,544	377	528	679	830
	Mount Rogers	12,853	643	900	1,157	1,414
	New River Valley	21,098	1,055	1,477	1,899	2,321
	Planning District 1	10,115	506	708	910	1,113
IV	Chesterfield	43,685	2,184	3,058	3,932	4,805
	Crossroads	11,871	594	831	1,068	1,306
	District 19	19,358	968	1,355	1,742	2,129
	Goochland-Powhatan	5,892	295	412	530	648
	Hanover County	13,685	684	958	1,232	1,505
	Henrico Area	39,281	1,964	2,750	3,535	4,321
	Richmond BHA	20,692	1,035	1,448	1,862	2,276
V	Chesapeake	30,188	1,509	2,113	2,717	3,321
	Colonial	20,425	1,021	1,430	1,838	2,247
	Eastern Shore	4,614	231	323	415	507
	Hampton-Newport News	38,370	1,919	2,686	3,453	4,221
	Middle Pen.-Northern Neck	14,883	744	1,042	1,340	1,637
	Norfolk	26,228	1,311	1,836	2,360	2,885
	Portsmouth	10,630	532	744	957	1,169
	Virginia Beach	52,949	2,647	3,706	4,765	5,824
	Western Tidewater	18,205	910	1,274	1,638	2,003
VI	Danville-Pittsylvania	11,741	587	822	1,057	1,291
	Piedmont	15,139	757	1,060	1,363	1,665
	Southside	9,421	471	659	848	1,036
VII	Alleghany Highlands	2,493	125	175	224	274
	Blue Ridge	28,118	1,406	1,968	2,531	3,093
	TOTAL	**944,195**	**47,210**	**66,094**	**84,978**	**103,861**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau
LOF = 50: lower 5%, upper 7%; LOF = 60: lower 9%, upper 11%.

Estimated Prevalence of Intellectual and Related Developmental Disabilities by CSB and Region

	CSB	Population Age 0-5 (2010 Estimate)	Estimated # Part C Eligible Infants/Toddlers 3%	Population Age 6+ (2007 Estimate	Estimated # With ID 1%	General Population	Estimated # With DD 1.8%
I	Central Virginia	17,311	519	235,811	2,358	252,634	4,547
	Harrisonburg-Rockingham	8,542	256	116,737	1,167	125,228	2,254
	Northwestern	17,316	519	205,570	2,056	222,152	3,999
	Rappahannock Area	29,465	884	300,494	3,005	327,773	5,900
	Rappahannock-Rapidan	13,595	408	153,606	1,536	166,054	2,989
	Region Ten	16,072	482	218,543	2,185	234,712	4,225
	Rockbridge Area	2,336	70	38,530	385	40,730	733
	Valley	8,495	255	112,621	1,126	120,823	2,175
II	Alexandria	7,625	229	128,731	1,287	139,966	2,519
	Arlington	11,008	330	194,010	1,940	207,627	3,737
	Fairfax-Falls Church	89,704	2,691	1,026,659	10,267	1,116,623	20,099
	Loudoun County	34,798	1,044	278,973	2,790	312,311	5,622
	Prince William County	44,548	1,336	408,960	4,090	454,096	8,174
III	Cumberland Mountain	6,356	191	92,026	920	98,073	1,765
	Dickenson County	1,097	33	14,845	148	15,903	286
	Highlands	4,855	146	68,078	681	72,711	1,309
	Mount Rogers	8,056	242	113,216	1,132	120,884	2,176
	New River Valley	10,409	312	168,037	1,680	178,237	3,208
	Planning District 1	6,218	187	88,084	881	94,174	1,695
IV	Chesterfield	27,349	820	291,781	2,918	316,236	5,692
	Crossroads	6,859	206	97,879	979	104,609	1,883
	District 19	12,325	370	161,256	1,613	173,463	3,122
	Goochland-Powhatan	3,556	107	46,739	467	49,763	896
	Hanover County	8,275	248	93,011	930	99,863	1,798
	Henrico Area	26,279	788	306,510	3,065	332,620	5,987
	Richmond BHA	12,319	370	189,363	1,894	204,214	3,676
V	Chesapeake	18,407	552	204,741	2,047	222,209	4,000
	Colonial	11,660	350	148,504	1,485	158,691	2,856
	Eastern Shore	3,188	96	42,399	424	45,553	820
	Hampton-Newport News	24,292	729	291,806	2,918	318,155	5,727
	Middle Pen.-Northern Neck	9,337	280	132,767	1,328	141,255	2,543
	Norfolk	16,856	506	223,500	2,235	242,803	4,370
	Portsmouth	7,597	228	87,219	872	95,535	1,720
	Virginia Beach	34,105	1,023	403,085	4,031	437,994	7,884
	Western Tidewater	12,098	363	135,603	1,356	147,007	2,646
VI	Danville-Pittsylvania	7,440	223	99,310	993	106,561	1,918
	Piedmont	9,432	283	133,204	1,332	142,621	2,567
	Southside	5,728	172	81,042	810	86,402	1,555
VII	Alleghany Highlands	1,541	46	20,832	208	22,211	400
	Blue Ridge	17,771	533	234,946	2,349	252,548	4,546
	TOTAL	**614,219**	**18,427**	**7,389,029**	**73,890**	**8,001,024**	**144,018**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau

Estimated Prevalence of Drug and Alcohol Dependence by CSB and Region

	CSB	Population 12+ (2010 Estimate)	Estimated Drug Dependence 1.92 %	Estimated Alcohol Dependence 3.58%	Total Estimated # Drug/Alcohol Dependence*
I	Central Virginia	218,140	4,188	7,809	11,998
	Harrisonburg-Rockingham	108,241	2,078	3,875	5,953
	Northwestern	188,152	3,613	6,736	10,348
	Rappahannock Area	270,513	5,194	9,684	14,878
	Rappahannock-Rapidan	139,775	2,684	5,004	7,688
	Region Ten	202,526	3,888	7,250	11,139
	Rockbridge Area	36,122	694	1,293	1,987
	Valley	104,092	1,999	3,727	5,725
II	Alexandria	121,796	2,338	4,360	6,699
	Arlington	183,749	3,528	6,578	10,106
	Fairfax-Falls Church	937,049	17,991	33,546	51,538
	Loudoun County	245,666	4,717	8,795	13,512
	Prince William County	365,168	7,011	13,073	20,084
III	Cumberland Mountain	85,521	1,642	3,062	4,704
	Dickenson County	13,726	264	491	755
	Highlands	63,213	1,214	2,263	3,477
	Mount Rogers	105,004	2,016	3,759	5,775
	New River Valley	157,626	3,026	5,643	8,669
	Planning District 1	81,749	1,570	2,927	4,496
IV	Chesterfield	263,870	5,066	9,447	14,513
	Crossroads	90,915	1,746	3,255	5,000
	District 19	148,850	2,858	5,329	8,187
	Goochland-Powhatan	43,068	827	1,542	2,369
	Hanover County	84,415	1,621	3,022	4,643
	Henrico Area	280,131	5,379	10,029	15,407
	Richmond BHA	177,482	3,408	6,354	9,762
V	Chesapeake	185,706	3,566	6,648	10,214
	Colonial	136,373	2,618	4,882	7,501
	Eastern Shore	39,271	754	1,406	2,160
	Hampton-Newport News	267,737	5,141	9,585	14,726
	Middle Peninsula-Northern Neck	123,291	2,367	4,414	6,781
	Norfolk	207,332	3,981	7,422	11,403
	Portsmouth	79,908	1,534	2,861	4,395
	Virginia Beach	368,733	7,080	13,201	20,280
	Western Tidewater	123,480	2,371	4,421	6,791
VI	Danville-Pittsylvania	91,739	1,761	3,284	5,046
	Piedmont	123,622	2,374	4,426	6,799
	Southside	75,130	1,442	2,690	4,132
VII	Alleghany Highlands	19,249	370	689	1,059
	Blue Ridge	216,920	4,165	7,766	11,931
	TOTAL	**6,775,052**	**130,081**	**242,547**	**372,628**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau
*Note: Total includes a duplicated count of persons with co-occurring drug and alcohol dependence.

Appendix F
Individuals on Waiting Lists for Services by CSB

Adults on CSB Mental Health Services Waiting Lists -- January - April 2011

	CSB	Adult SMI Prevalence	Unduplicated # Served (FY 2011)			On CSB Waiting Lists		Total on CSB Waiting List
			# Served	# SMI	% with SMI	Receiving CSB Svs	Not Receiving CSB Svs	
I	Central Virginia	7,760	2,457	2,107	86%	17	5	**22**
	Harrisonburg-Rockingham	3,893	1,284	620	48%	40	1	**41**
	Northwestern	6,627	1,370	680	50%	17	22	**39**
	Rappahannock Area	9,296	2,992	930	31%	85	96	**181**
	Rappahannock-Rapidan	4,892	1,840	776	42%	92	0	**92**
	Region Ten	7,262	2,245	831	37%	91	67	**158**
	Rockbridge	1,307	734	289	39%	14	0	**14**
	Valley	3,713	1,759	569	32%	21	42	**63**
II	Alexandria	4,524	1,596	1,061	66%	43	16	**59**
	Arlington	6,825	2,073	1,417	68%	40	0	**40**
	Fairfax-Falls Church	33,007	4,525	4,038	89%	316	25	**341**
	Loudoun	8,458	1,418	614	43%	45	58	**103**
	Prince William	12,601	2,177	1,547	71%	283	39	**322**
III	Cumberland Mountain	3,061	1,197	980	82%	127	5	**132**
	Dickenson County	491	692	524	76%	0	0	**0**
	Highlands	2,272	2,410	1,444	60%	33	0	**33**
	Mount Rogers	3,749	2,587	2,242	87%	440	2	**442**
	New River Valley	5,736	2,520	1,516	60%	95	1	**96**
	P.D. 1	2,927	2,400	1,404	59%	56	16	**72**
IV	Chesterfield	9,115	2,310	1,232	53%	70	29	**99**
	Crossroads	3,256	1,896	1,123	59%	21	56	**77**
	District 19	5,293	1,734	880	51%	3	38	**41**
	Goochland-Powhatan	1,517	337	98	29%	0	3	**3**
	Hanover	2,920	642	481	75%	58	0	**58**
	Henrico	9,861	2,254	1,501	67%	224	0	**224**
	Richmond BHA	6,482	2,138	1,692	79%	321	30	**351**
V	Chesapeake	6,423	1,297	555	43%	57	1	**58**
	Colonial	4,784	1,769	678	38%	62	4	**66**
	Eastern Shore	1,411	854	449	53%	3	0	**3**
	Hampton-Newport News	9,476	5,488	2,447	45%	13	1	**14**
	Middle Pen-Northern Neck	4,405	2,121	1,139	54%	37	127	**164**
	Norfolk	7,495	2,633	1,781	68%	75	14	**89**
	Portsmouth	2,842	1,303	833	64%	0	0	**0**
	Virginia Beach	12,977	2,226	1,563	70%	106	53	**159**
	Western Tidewater	4,324	874	698	80%	43	0	**43**
VI	Danville-Pittsylvania	3,269	1,396	820	59%	43	18	**61**
	Piedmont	4,419	2,679	1,379	51%	44	33	**77**
	Southside	2,678	1,363	815	60%	1	25	**26**
VII	Alleghany Highlands	682	669	344	51%	25	1	**26**
	Blue Ridge	7,715	2,371	1,866	79%	126	2	**128**
	TOTAL	**239,747**	**76,630***	**45,963***	**60%**	**3,187**	**830**	**4,017**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau

Children and Adolescents on CSB Mental Health Services Waiting Lists – January - April 2011

	CSB	SED Prevalence (LOF = 50 Upper Range)	Unduplicated # Served (FY 2011 # Served SED	# SED	% with	On CSB Waiting Lists Receiving CSB Svs	Not Receiving CSB Svs	Total on CSB Waiting List
	Central Virginia	2,128	2,391	1,661	69%	73	4	**77**
	Harrisonburg-Rockingham	1,144	495	394	80%	10	2	**12**
	Northwestern	1,871	574	310	54%	6	0	**6**
	Rappahannock Area	3,253	1,417	441	31%	21	21	**42**
	Rappahannock-Rapidan	1,458	562	408	73%	1	0	**1**
	Region Ten	1,838	1,162	475	41%	33	3	**36**
	Rockbridge	318	220	175	80%	0	0	**0**
	Valley	923	775	236	30%	24	9	**33**
II	Alexandria	621	361	247	68%	1	18	**19**
	Arlington	933	380	233	61%	12	34	**46**
	Fairfax-Falls Church	9,179	1,594	1,012	63%	49	21	**70**
	Loudoun	2,983	374	250	67%	9	15	**24**
	Prince William	4,340	417	254	61%	34	51	**85**
III	Cumberland Mountain	720	826	724	88%	202	0	**202**
	Dickenson County	121	193	140	73%	0	0	**0**
	Highlands	528	1,206	783	65%	32	0	**32**
	Mount Rogers	900	1,408	1,089	77%	290	0	**290**
	New River Valley	1,477	2,203	1,511	69%	122	6	**128**
	P.D. 1	708	1,264	790	63%	10	1	**11**
IV	Chesterfield	3,058	470	200	43%	61	38	**99**
	Crossroads	831	476	299	63%	18	13	**31**
	District 19	1,355	663	400	60%	0	1	**1**
	Goochland-Powhatan	412	70	17	24%	0	0	**0**
	Hanover	958	262	205	78%	0	0	**0**
	Henrico	2,750	1,002	520	52%	82	10	**92**
	Richmond BHA	1,448	1,218	1,013	83%	85	0	**85**
V	Chesapeake	2,113	228	82	36%	0	0	**0**
	Colonial	1,430	556	266	48%	3	0	**3**
	Eastern Shore	323	405	227	56%	1	0	**1**
	Hampton-Newport News	2,686	2,720	2,379	87%	0	0	**0**
	Middle Pen.-Northern Neck	1,042	1,055	620	59%	24	65	**89**
	Norfolk	1,836	460	173	38%	0	0	**0**
	Portsmouth	744	35	33	94%	0	0	**0**
	Virginia Beach	3,706	415	252	61%	10	12	**22**
	Western Tidewater	1,274	523	324	62%	28	0	**28**
VI	Danville-Pittsylvania	822	401	332	83%	13	4	**17**
	Piedmont	1,060	982	566	58%	33	41	**74**
	Southside	659	427	364	85%	0	0	**0**
VII	Alleghany Highlands	175	187	74	40%	4	0	**4**
	Blue Ridge	1,968	885	772	87%	36	3	**39**
	TOTAL	**66,094**	31,262	20,251	65%	**1,327**	**372**	**1,699**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau

Individuals on CSB Developmental Services Waiting Lists – January - April 2011

	CSB	ID Prevalence Age 6 and Over	Unduplicated # Served (FY 2011)	On CSB Waiting Lists				Totals on CSB Adult and Children/Adolescents Waiting Lists		
				Receiving CSB Services		Not Receiving Some CSB Services				
				Adult	C/A	Adult	C/A	Adult	C/A	Total
I	Central Virginia	235,811	807	110	1	68	0	178	1	**179**
	Harrisonburg-Rockingham	116,737	234	28	20	17	22	45	42	**87**
	Northwestern	205,570	670	54	14	11	2	65	16	**81**
	Rappahannock Area	300,494	711	35	88	30	77	65	165	**230**
	Rappahannock-Rapidan	153,606	447	31	10	7	16	38	26	**64**
	Region Ten	218,543	464	70	9	27	7	97	16	**113**
	Rockbridge	38,530	146	17	2	15	1	32	3	**35**
	Valley	112,621	447	104	8	45	2	149	10	**159**
II	Alexandria	128,731	131	0	7	0	0	0	7	**7**
	Arlington	194,010	265	54	26	0	0	54	26	**80**
	Fairfax-Falls Church	1,026,659	1,888	568	121	92	223	660	344	**1,004**
	Loudoun	278,973	246	118	45	22	61	140	106	**246**
	Prince William	408,960	539	79	81	8	51	87	132	**219**
III	Cumberland Mountain	92,026	342	41	0	41	0	82	0	**82**
	Dickenson County	14,845	31	4	0	0	0	4	0	**4**
	Highlands	68,078	189	25	6	19	8	44	14	**58**
	Mount Rogers	113,216	808	53	4	122	2	175	6	**181**
	New River Valley	168,037	311	6	6	57	22	63	28	**91**
	P.D. 1	88,084	337	8	10	13	12	21	22	**43**
IV	Chesterfield	291,781	1,332	527	2	336	1	863	3	**866**
	Crossroads	97,879	212	10	31	6	16	16	47	**63**
	District 19	161,256	342	45	0	13	1	58	1	**59**
	Goochland-Powhatan	46,739	102	13	0	13	1	26	1	**27**
	Hanover	93,011	311	88	2	33	15	121	17	**138**
	Henrico	306,510	1,305	232	0	153	0	385	0	**385**
	Richmond Behavioral	189,363	955	164	2	142	0	306	2	**308**
V	Chesapeake	204,741	368	65	5	9	5	74	10	**84**
	Colonial	148,504	158	38	21	27	0	65	21	**86**
	Eastern Shore	42,399	142	6	1	0	1	6	2	**8**
	Hampton-Newport News	291,806	1,470	115	5	86	12	201	17	**218**
	Middle Pen.-Northern Neck	132,767	335	53	7	45	16	98	23	**121**
	Norfolk	223,500	542	84	0	16	0	100	0	**100**
	Portsmouth	87,219	281	14	16	3	2	17	18	**35**
	Virginia Beach	403,085	901	148	63	39	99	187	162	**349**
	Western Tidewater	135,603	613	83	9	14	2	97	11	**108**
VI	Danville-Pittsylvania	99,310	422	75	16	34	13	109	29	**138**
	Piedmont	133,204	447	46	23	15	12	61	35	**96**
	Southside	81,042	226	10	15	3	11	13	26	**39**
VII	Alleghany Highlands	20,832	103	7	2	5	5	12	7	**19**
	Blue Ridge	234,946	807	99	35	20	51	119	86	**205**
	TOTAL	**7,389,029**	**20,387**	**3,327**	**713**	**1,606**	**769**	**4,933**	**1,482**	**6,415**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau

Adults and Adolescents on CSB Substance Abuse Services Waiting Lists – January - April 2011

	CSB	Drug & Alcohol Dependence Prevalence	Unduplicated # Served (FY 2011)	On CSB Waiting Lists: Receiving CSB Services		Not Receiving Some CSB Services		Totals on CSB Adult and Adolescent Waiting Lists		
				Adult	Adol.	Adult	Adol.	Adult	Adolescent	Total
I	Central Virginia	11,212	660	0	0	0	0	0	0	**0**
	Harrisonburg-Rockingham	5,564	434	11	1	0	1	12	1	**26**
	Northwestern	9,671	286	5	11	0	0	16	0	**32**
	Rappahannock Area	13,904	1347	37	1	1	0	38	1	**78**
	Rappahannock-Rapidan	7,184	770	6	0	0	0	6	0	**12**
	Region Ten	10,410	1288	13	20	0	0	33	0	**66**
	Rockbridge	1,857	197	0	0	0	0	0	0	**0**
	Valley	5,350	1092	10	31	0	1	41	1	**84**
II	Alexandria	6,260	727	22	13	0	0	35	0	**70**
	Arlington	9,445	1029	4	0	2	6	4	8	**24**
	Fairfax-Falls Church	48,164	3325	174	31	8	0	205	8	**426**
	Loudoun	12,627	898	15	159	1	7	174	8	**364**
	Prince William	18,770	1369	12	3	2	11	15	13	**56**
III	Cumberland Mountain	4,396	1803	7	0	7	0	7	7	**28**
	Dickenson County	706	346	9	3	0	0	12	0	**24**
	Highlands	3,249	428	0	0	0	0	0	0	**0**
	Mount Rogers	5,397	666	46	0	4	0	46	4	**100**
	New River Valley	8,102	747	23	73	4	0	96	4	**200**
	P.D. 1	4,202	988	48	32	0	0	80	0	**160**
IV	Chesterfield	13,563	1339	392	61	15	0	453	15	**936**
	Crossroads	4,673	502	14	28	0	0	42	0	**84**
	District 19	7,651	1147	0	7	0	0	7	0	**14**
	Goochland-Powhatan	2,214	99	0	14	0	0	14	0	**28**
	Hanover	4,339	281	28	1	0	0	29	0	**58**
	Henrico	14,399	2235	0	1	1	1	1	2	**6**
	Richmond Behavioral	9,123	1484	68	73	9	4	141	13	**308**
V	Chesapeake	9,545	979	24	1	0	0	25	0	**50**
	Colonial	7,010	856	5	5	0	0	10	0	**20**
	Eastern Shore	2,019	234	0	0	0	0	0	0	**0**
	Hampton-Newport News	13,762	2267	2	0	0	0	2	0	**4**
	Middle Pen.-Northern Neck	6,337	607	0	7	0	3	7	3	**20**
	Norfolk	10,657	1858	39	44	0	0	83	0	**166**
	Portsmouth	4,107	882	12	0	0	0	12	0	**24**
	Virginia Beach	18,953	432	10	28	0	9	38	9	**94**
	Western Tidewater	6,347	278	0	8	0	0	8	0	**16**
VI	Danville-Pittsylvania	4,715	414	0	1	0	0	1	0	**2**
	Piedmont	6,354	829	6	23	1	3	29	4	**66**
	Southside	3,862	309	0	8	0	0	8	0	**16**
VII	Alleghany Highlands	989	270	0	0	0	0	0	4	**4**
	Blue Ridge	11,150	1067	26	16	0	0	42	0	**84**
	TOTAL	**348,238**	**36,769**	**1,068**	**704**	**55**	**46**	**1,772**	**105**	**3,750**

Source for population counts: 2010 DP1 Profile of general demographic characteristics, US Census Bureau

Appendix G
Proposed State Facility Capital Projects Priority Listing 2012 – 2018

	Proposed Capital Projects	Estimated Resource Requirements
2011-13 Biennium (FY 2012 and FY 2013)	Replace Facility Roofs and Building Envelopes	$13,863,000
	Furniture, Fixture and Equipment for New Western State Hospital	$13,326,000
	Repair/replace campus infrastructure	$8,020,000
	Repair/Replace Boilers, Heat Distribution and HVAC System	$26,381,000
	Construct New Sexually Violent Predator Facility (Detailed Planning)	$4,800,000
	Replace Forensic Unit at Central State Hospital (Detailed Planning)	$6,900,000
	Replace Support Services Facility at Eastern State Hospital (Detailed Planning)	$2,420,500
	Renovate Building 96 at Central State Hospital	$4,675,000
	Renovate Main Hospital Building at Piedmont Geriatric Hospital (Detailed Planning)	$4,120,000
	Renovate Northern Virginia Training Center (Detailed Planning)	$841,500
	Abate Environmental Hazards (Detailed Planning)	$475,200
	2011-2013 Estimated Resource Requirements Subtotal	**$85,822,200**
2013-15 Biennium (FY 2014 and FY 2015)		$10,158,000
	Repair/replace campus infrastructure (phase 2)	$15,940,000
	Repair/replace boilers, heat distribution and HVAC systems (phase 2)	$26,309,000
	Abate hazardous materials	$2,140,000
	Construct new sexually violent predator facility (phase 2)	$56,646,000
	Replace support service facility at Eastern State Hospital	$12,161,000
	Replace forensic unit at Central State Hospital	$93,233,000
	2012-2014 Estimated Resource Requirements Subtotal	**$216,587,000**
2015-16 Biennium (FY 2016 and FY 2017)	Repair/replace boilers, heat distribution and HVAC systems (phase 3)	**$13,731,000**
Project Total Resource Requirements	Replace facility roofs and building envelopes	$22,569,000
	Repair/replace campus infrastructure	$24,974,000
	Repair/replace boilers, heat distribution and HVAC systems	$59,817,000
	Abate hazardous materials	$7,970,000
	Construct new sexually violent predator facility	$85,622,000
	Replace support service facility at Eastern State Hospital	$29,621,000
	Replace forensic unit at Central State Hospital	$99,089,000
	Renovate bathrooms at Northern Virginia Training Center	$2,901,000
	Construct replacement facility for Piedmont Geriatric Hospital	$54,637,000
	Renovate buildings 10 and 47 at Central Virginia Training Center	$14,393,000
	Six Year Resource Requirements Total	**$401,593,000**

Appendix H
Glossary of Services and Services System Terms and Acronyms

Acronym/Term	Name
AA	Alcoholics Anonymous
AAIDD	American Association on Intellectual and Developmental Disabilities
ABS	Adaptive Behavior Scale (ID)
ACA	Annual Consultative Audit (DBHDS)
ACF	Administration on Children and Families (U.S.)
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act (U.S.) or Assistant Director Administrative (DBHDS facility position)
ADC	Average Daily Census
ADD	U.S. Administration on Developmental Disabilities (U.S.)
ADRDA	Alzheimer's Disease and Related Disorders Association
ADSCAP	AIDS Control and Prevention Project
AHCPR	Agency for Health Care Policy and Research (U.S.)
AHP	Advocates for Human Potential
AITR	Agency Information Technology Resource (Virginia)
ALF	Assisted Living Facility (formerly Adult Care Residence)
ALOS	Average Length of Stay
AMA	Against Medical Advice or American Medical Association
AOD	Alcohol and Other Drugs
AODA	Alcohol and Other Drug Abuse
APA	Administrative Process Act (Virginia), American Psychiatric Association, or American Psychological Association
AR	Authorized Representative
Arc of Virginia	Advocacy group for individuals with intellectual disability
ARMICS	Agency Risk Management and Internal Controls
ARR	Annual Resident Review
ARRA	American Recovery and Reinvestment Act (U.S.)
ASD	Autism Spectrum Disorder
ASAM	American Society of Addiction Medicine
ASFA	Adoption and Safe Families Act of 1997 (U.S.)
ASI	Addiction Severity Index
AT	Assistive Technology
ATOD	Alcohol, Tobacco and Other Drugs
ATTC	Addiction Technology Transfer Center
AVATAR	State Facility Information Patient/Billing System (DBHDS information system)
AWOP	Absent Without Permission
BH	Behavioral Health
BHA	Behavioral Health Authority (Virginia)
BHS	Behavioral Health Services
C&A	Child and Adolescent
CAFAS	Child and Adolescent Functional Assessment Scale
CAPTA	Child Abuse Prevention Treatment Act (U.S.)
CARF	Commission on Accreditation of Rehabilitation Facilities
CARS	Community Automated Reporting System (DBHDS)
CASA	National Center on Addiction and Substance Abuse at Columbia University
CBT	Cognitive Behavioral Therapy
CCCA	Commonwealth Center for Children and Adolescents (DBHDS facility located in Staunton)
CCISC	Comprehensive, Continuous, Integrated System of Care model
CCS	Community Consumer Submission (DBHDS community information extract application)

CDC	Centers for Disease Control and Prevention (U.S.)
CDS	College of Direct Support
CELT	Consumer Education and Leadership Training
CH	Catawba Hospital (DBHDS facility located near Salem)
CHAP	Child Health Assistance Program
CHRIS	Comprehensive Human Rights Information System (DBHDS human rights application))
CLAS	Culturally and Linguistically Appropriate Services (HHS National Standards)
CM	Case Management
CMHS	Center for Mental Health Services (U.S.)
CMS	Centers for Medicare and Medicaid Services (U.S.)
CO	Central office (DBHDS)
Coalition	Coalition for Virginians with Mental Disabilities (Virginia)
COBRA	Comprehensive Omnibus Budget Reconciliation Act (also OBRA)
CODIE	Central office Data and Information Exchange (DBHDS intranet)
COPN	Certificate of Public Need
CORE	Council on Reform (Virginia Children's Services System Transformation)
COSIG	Co-Occurring State Incentive Grant
COY	Commission on Youth (Virginia)
COV	Commonwealth of Virginia
CPP	Certified Prevention Professional
CPMT	Community Policy and Management Team (Virginia CSA)
CRC	Commitment Review Committee (DBHDS)
CRF	Classification Rating Form (MH-Adult)
CRIPA	Civil Rights of Institutionalized Persons Act (U.S.)
CSA	Comprehensive Services Act for Troubled Children and Youth (Virginia)
CSAO	Consortium of Substance Abuse Organizations (Virginia)
CSAP	Center for Substance Abuse Prevention (U.S.)
CSAT	Center for Substance Abuse Treatment (U.S.)
CSB	Community Services Board (Virginia)
CSH	Central State Hospital (DBHDS facility located in Dinwiddie)
CSP	Community Support Program
CSS	Community Support System
CTI	Critical Time Intervention
CVTC	Central Virginia Training Center (DBHDS facility located near Lynchburg)
DAD Project	Discharge Assistance and Diversion Project (Northern Virginia)
DAP	Discharge Assistance Project
DBHDS	Department of Behavioral Health and Developmental Services (the Department) (Virginia)
DBSA	Depression and Bipolar Support Alliance
DCHVP	Domiciliary Care for the Homeless Veterans Program
DCJS	Department of Criminal Justice Services (Virginia)
DD	Developmental Disability
DDHH	Department for the Deaf and Hard of Hearing (Virginia)
DHCD	Department of Housing and Community Development (Virginia)
DHHS	Department of Health and Human Services (U.S.) (or HHS)
DI	Departmental Instruction (DBHDS internal policy and procedures)
DJJ	Department of Juvenile Justice (Virginia)
DMAS	Department of Medical Assistance Services (Virginia)
DMC	Data Management Committee of the VACSB
DOC	Department of Corrections (Virginia)
DOE	Department of Education (Virginia)
DOJ	Department of Justice (U.S.)
DPB	Department of Planning and Budget (Virginia)

DPSP	Division of Programs for Special Populations (U.S.)
DRGs	Diagnosis-Related Groups
DRS	Department of Rehabilitative Services (Virginia)
DSM-IV	Diagnostic and Statistical Manual (Mental Disorders), Fourth Edition
DV	Developmental Services
DVH	Department for the Visually Handicapped (Virginia)
DVS	Department of Veterans Services (Virginia)
EBP	Evidence-Based Practice
ECA	Epidemiologic Catchment Area
ECO	Emergency Custody Order (Virginia)
ED Forum	Executive Directors Forum of the VACSB (Virginia)
EHR	Electronic Health Record
EI	Early Intervention
EMTALA	Emergency Medical Treatment and Active Labor Act (U.S.)
EO	Executive Order (Virginia)
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (CMS)
ER	Emergency Room
ESH	Eastern State Hospital (DBHDS facility located in Williamsburg)
ESO	Employment Services Organization
FAPT	Family Assessment and Planning Team (Virginia)
FAS	Fetal Alcohol Syndrome
FFP	Federal Financial Participation (Medicaid)
FFS	Fee-for-Service
FHA	Federal Housing Administration (U.S.)
FIMS	Forensic Information System (DBHDS application)
FMLA	Family and Medical Leave Act (U.S.)
FMR	Fair Market Rent (U.S. Housing and Urban Development)
FMS	Financial Management System (DBHDS financial information system)
FRP	Forensic Review Panel (DBHDS)
FSO	Facility Security Officer (DBHDS)
FTE	Full Time Equivalent
FY	Fiscal Year -State (SFY)-July 1 to June 30; Federal (FFY) - October 1 to September 30
GA	General Assembly (Virginia)
GAF	Global Assessment of Functioning
GOSAP	Governor's Office for Substance Abuse Prevention (Virginia)
HD	House Document (Virginia)
HGTC	Hancock Geriatric Treatment Center (at Eastern State Hospital in Williamsburg)
HHR	Health and Human Resources Secretariat (Virginia)
HIE	Health Information Exchange or Homeless Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HJR	House Joint Resolution (also HJ) (Virginia)
HMO	Health Maintenance Organization
HPO	High Performance Organization
HPR	Health Planning Region (Virginia)
HPSA	Health Professional Shortage Area
HRIS	Human Resources Information System (Virginia)
HRSA	Health Resources and Services Administration (U.S.)
HSA	Health Services Area
HUD	Housing and Urban Development (U.S.)
HVAC	Heating, Ventilation, and Air Conditioning
HDMC	Hiram W. Davis Medical Center (DBHDS facility located in Dinwiddie)
I&R	Information and Referral

IAPSRS	International Association of Psychosocial Rehabilitation Services
ICD	International Classification of Diseases
ICF	Intermediate Care Facility (CMS)
ICF/MR	Intermediate Care Facility for the Mentally Retarded (CMS)
ICT	Intensive Community Treatment
ID	Intellectual Disability
ID/MI	Intellectual Disability/Mental Illness (co-occurring diagnosis)
IDDT	Integrated Dual Disorders Treatment
IDEA	Individuals with Disabilities Education Act (U.S.)
ID waiver	Medicaid Home and Community-Based Waive, formerly the MR waiver (CMS)
IFDDS	Individuals and Families Developmental Disabilities Waiver Services (CMS)
ILPPP	University of Virginia Institute of Law, Psychiatry and Public Policy
IM	Investigations Manager (DBHDS central office)
IMD	Institution for the Mentally Disabled (CMS)
IM&R	Illness Management and Recovery
IP	Inpatient
IPA	Independent Practice Association
IQ	Intelligence Quotient
IS	Information Systems
ISN	Integrated Service Network
ISO	Information Security Officer (DBHDS central office)
ISP	Individualized Services Plan or Integrated Strategic Plan (DBHDS plan)
IT	Information Technology
ITIB	Information Technology Investment Board (DBHDS)
ITOTS	Infant and Toddler Information System (DBHDS application)
JAIBC	Juvenile Accountability Incentive Block Grant (U.S.)
JCHC	Joint Commission on Health Care (Virginia legislative commission))
JJDPA	Juvenile Justice Delinquency Prevention Act (U.S.)
JLARC	Joint Legislative Audit and Review Commission (Virginia legislative commission)
LEP	Limited English Proficiency
LGD	Local Government Department (a type of CSB)
LHRC	Local Human Rights Committee (Virginia)
LICC	Local Interagency Coordinating Council (Part C) (Virginia)
LOF	Level of Functioning
LOS	Length of Stay
LSC	Life Safety Code
LTC	Long Term Care
LTESS	Long-term Employment Support Services
MCH	Maternal and Child Health
MCO	Managed Care Organization
Medicaid DSA	Medicaid Disproportionate Share Adjustments
Medicaid DSH	Medicaid Disproportionate Share Hospital
MESA	Mutual Education, Support, and Advocacy
MET	Motivational Enhancement Therapy
MFP	Money Follows the Person (CMS initiative)
MH	Mental Health
MHT SIG	Mental Health Transformation State Incentive Grant
MHA-V	Mental Health America – Virginia (formerly Mental Health Association of Virginia)
MHI	Mental Health Institute
MHPC	Mental Health Planning Council (Virginia)
MHPRC	Mental Health Policy Resource Center
MHSIP	Mental Health Statistics Improvement Program

MIC	Maternal and Infant Care
Mid-ATTC	Mid Atlantic Addiction Technology Transfer Center
MI/ID	Mental Illness/Intellectual Disability (co-occurring diagnosis)
MI/SUD	Mental Illness/Substance Use Disorder (co-occurring diagnosis)
MITA	Medicaid Information Technology Architecture
MMWR	Morbidity and Mortality Weekly Report
MOA	Memorandum of Agreement
MOT	Mandatory Outpatient Treatment
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MST	Multi-systemic Therapy
MUA	Medically Underserved Area
NA	Narcotics Anonymous
NADD	National Association for the Dually Diagnosed
NAEH	National Alliance to End Homelessness
NAFARE	National Association for Family Addiction, Research and Education
NAMI	National Alliance for the Mentally Ill
NAMI -VA	National Alliance for the Mentally Ill - Virginia
NAPH	National Association of Public Hospitals
NAPWA	National Association of People with AIDS
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NADDDS	National Association of Directors of Developmental Disabilities Services
NSDUH	National Household Survey on Drug Use and Health
NASMHPD	National Association of State Mental Health Program Directors
NASTAD	National Alliance of State and Territorial AIDS Directors
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NCSACW	National Center for Substance Abuse and Child Welfare
NCCAN	National Center on Child Abuse and Neglect
NCH	National Coalition for the Homeless
NCS	National Comorbidity Survey
NCSACW	National Center for Substance Abuse and Child Welfare
NF	Nursing Facility
NGF	Non-general Funds (Virginia)
NGRI	Not Guilty by Reason of Insanity
NHCHC	National Health Care for the Homeless Council
NHIS-D	National Health Interview Survey Disability Supplement
NIAAA	National Institute on Alcohol and Alcohol Abuse (U.S.)
NIATx	Network to Improve Addiction Treatment
NIDA	National Institute on Drug Abuse (U.S.)
NIH	National Institutes of Health (U.S.)
NIMH	National Institute on Mental Health (U.S.)
NOMS	National Outcomes Measures (SAMHSA)
NSDUH	National Household Survey on Drug Use and Health
NVMHCA	Northern Virginia Mental Health Consumers Association
NVMHI	Northern Virginia Mental Health Institute (DBHDS facility located in Falls Church)
NVTC	Northern Virginia Training Center (DBHDS facility located in Fairfax)
OAG	Office of the Attorney General (Virginia)
OBRA	Omnibus Budget Reconciliation Act of 1989 (U.S.)
OBS	Organic Brain Syndrome
OIG	Office of the Inspector General for Behavioral Health and Developmental Services (Virginia)
OLIS	Office of Licensing Information System (DBHDS licensing application)

OMHRC	Office of Minority Health Resource Center (U.S.)
ONAP	Office of National AIDS Policy (U.S.)
OP	Outpatient
OT	Occupational Therapy
PACT	Program of Assertive Community Treatment
PAIMI	Protection and Advocacy for Individuals with Mental Illnesses Act (U.S.)
PAIR	Parents and Associates of the Institutionalized Retarded
Part C	Part C of the IDEA (Federal funds for early intervention services)
PASARR	Pre-Admission Screening/Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness (federal grant)
PBPS	Performance-Based Prevention System
PBS	Positive Behavioral Supports
PCP	Person Centered Planning
PD	Planning District (Virginia)
PEATC	Parent Educational Advocacy Training Center
PGH	Piedmont Geriatric Hospital (DBHDS facility located in Burkeville)
PHA	Public Health Association
PHS	Public Health Service (U.S.)
PIP	Program Improvement Plan
PKI	Public Key Infrastructure
PL	Public Law (U.S.)
PMPM	Per Member Per Month
POIS	Purchase of Individualized Services
POS	Purchase of Services
PPAC	Prevention and Promotion Advisory Council
PPACA	Patient Protection and Affordable Care Act (U.S.)
PPC	Patient Placement Criteria
PPEA	Public Private Educational and Infrastructure Act of 2002 (Virginia)
PPO	Preferred Provider Organization
PPW	Pregnant and Postpartum Women
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (U.S)
PRAIS	Patient Resident Automated Information System (DBHDS application, now AVATAR))
PRC	Perinatal Resource Center
PSR	Psychosocial Rehabilitation
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMRP	Qualified Mental Retardation Professional
RCSC	Regional Community Support Center
REACH	Recovery, Education and Creative Healing
Region I	Northwest Virginia
Region II	Northern Virginia
Region III	Far Southwestern Virginia
Region IV	Central Virginia
Region V	Eastern Virginia
Region VI	Southside Virginia
Region VII	Catawba Virginia
RM	Risk Management
ROSI	Recovery-Oriented System Indicator survey
RPP	Regional Planning Partnership

SA	Substance Abuse
SAARA	Substance Abuse and Addiction Recovery Alliance (Virginia)
SAC	State Adolescent Treatment Coordination Grant
S+C	Shelter Plus Care
SACAVA	Substance Abuse Certification Alliance of Virginia
SAMHSA	Substance Abuse and Mental Health Services Administration (U.S.)
SANAP	Substance Abuse Needs Assessment Project
SAPT	Substance Abuse Prevention and Treatment (federal block grant)
SD	Senate Document (Virginia)
SDLC	System Development Life Cycle
SE	Supported Employment
SEC	State Executive Council (of Comprehensive Services Act)
SED	Serious Emotional Disturbance
SELN	Supported Employment Leadership Network
SERG	State Emergency Response Grant (U.S.)
SEVTC	Southeastern Virginia Training Center (DBHDS facility located in Chesapeake)
SGF	State General Funds
SHRC	State Human Rights Committee
SIS™	Supports Intensity Scale
SJR	Senate Joint Resolution (also SJ)
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility
SOAR	SSI Outreach and Recovery evidence based practice
SPF-SIG	Strategic Prevention Framework State Prevention Grant
SPMI	Serious and Persistent Mental Illness
SPO	State Plan Option (CMS), Single Room Occupancy, or School Resource Officer
SSA	Social Security Administration (U.S.)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
State Board	State Board of Behavioral Health and Developmental Services (Virginia)
STD	Sexually Transmitted Disease
STI	System Transformation Initiative (Virginia)
SUD	Substance Use Disorder (alcohol or other drug dependence or abuse)
SVMHI	Southern Virginia Mental Health Institute (DBHDS facility located in Danville)
SVP	Sexually Violent Predator
SVTC	Southside Virginia Training Center (DBHDS facility located in Dinwiddie)
SWVBHB	Southwest Virginia Behavioral Health Board
SWVMHI	Southwestern Virginia Mental Health Institute (DBHDS facility located in Marion)
SWVTC	Southwestern Virginia Training Center (DBHDS facility located in Hillsville)
TACIDD	The Advisory Consortium on Intellectual and Developmental Disabilities
TANF	Temporary Assistance for Needy Families (federal block grant)
TBI	Traumatic Brain Injury
TC	Training Center (state ICF of individuals with intellectual disability)
TDO	Temporary Detention Order (Virginia)
TEDS	Treatment Episode Data Set
TFSASO	Task Force on Substance Abuse Services for Offenders (Virginia)
TIP	Treatment Improvement Protocols (CSAT)
TJC	The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations)
TOVA	Therapeutic Options of Virginia
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999 (U.S.)

UAI	Uniform Assessment Instrument
UM	Utilization Management
UR	Utilization Review
URICA	University of Rhode Island Change Assessment
U.S.	United States
VA	Department of Veterans Affairs (U.S.)
VaACCESS	Virginia Association of Community Rehabilitation Programs
VAADAC	Virginia Association of Alcoholism and Drug Abuse Counselors
VACSB	Virginia Association of Community Services Boards
VACO	Virginia Association of Counties
VADAP	Virginia Association of Drug and Alcohol Programs
VAFC	Virginia Association of Free Clinics
VAFOF	Virginia Federation of Families
VAHA	Virginia Adult Home Association
VAHMO	Virginia Association of Health Maintenance Organizations
VALHSO	Virginia Association of Local Human Services Officials
VANHA	Virginia Association of Nonprofit Homes for the Aging
VASAP	Virginia Alcohol Safety Action Program (Commission on)
VASIP	Virginia Service Integration Program (formerly COSIG)
VASH	Veterans Administration Supported Housing
VATTC	Virginia Addictions Technology Transfer Center
VBPD	Virginia Board for People with Disabilities
VCBR	Virginia Center for Behavioral Rehabilitation (DBHDS facility located in Burkeville)
VDEM	Virginia Department of Emergency Management (Virginia)
VDMDA	Virginia Depressive and Manic-Depressive Association
VEAD	Virginia Enterprise Architecture Division (Virginia) (formerly Virginia Enterprise Architecture Program)
VEC	Virginia Employment Commission (Virginia)
VHHA	Virginia Hospital and Healthcare Association
VHCA	Virginia Health Care Association
VHDA	Virginia Housing Development Authority (Virginia)
VHST	Virginia Human Services Training Center
VICC	Virginia Interagency Coordinating Council
VIACH	Virginia Interagency Action Council on Homelessness
VICH	Virginia Interagency Council on Homelessness
VIPACT	Virginia Institute for Professional Addictions Counselor Training
VITA	Virginia Information Technologies Agency (Virginia)
VITC	Virginia Intercommunity Transition Council
VML	Virginia Municipal League
VNPP	Virginia Network of Private Providers
VOCAL	Virginia Association of Consumers Asserting Leadership
VOPA	Virginia Office for Protection and Advocacy (Virginia)
VPCA	Virginia Primary Care Association
VPN	Virtual Private Network
VR	Vocational Rehabilitation
VRHRC	Virginia Rural Health Resource Center
VVC	Voices for Virginia's Children
VWWP	Virginia Wounded Warriors Program
WIB	Workforce Investment Board
WRAP	Wellness Recovery Action Plan
WSH	Western State Hospital (DBHDS facility located in Staunton)

Appendix I

Comprehensive State Plan 2010-2016 Reference Documents

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